

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436

CERTIFICATE OF DEATH

Reg. Dist. No. 11432

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KALLS NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>Lula</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Havase</u>		14. MOTHER'S MAIDEN NAME <u>Cleatie Baire</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Eugenia J. Seeger</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>58</u> , to <u>10/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. NW Wash. D.C.</u> DATE SIGNED <u>10/1/58</u>			
ACTUAL SIGNATURE <u>Lawrence A. Rapee</u> M.D.			
PHYSICIAN'S NAME (Type) <u>LAWRENCE A. RAPEE, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>10/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MAPLE GROVE Cem.</u>	22d. LOCATION (City, town, or county) <u>FINDLAY</u> (State) <u>OHIO</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Benders</u>		24a. REC'D BY REGISTRAR <u>ACT 3 '58</u>	
ADDRESS <u>1756 Penna. Ave. NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

11136

11136

1. NAME OF DECEASED <i>Infante Mary Taylor</i>		2. SEX <i>Female</i>		3. AGE <i>1 year</i>	
4. PLACE OF BIRTH <i>St. Louis, Mo.</i>		5. DATE OF BIRTH <i>8/22/11</i>		6. TIME OF BIRTH <i>5:40 PM</i>	
7. PLACE OF DEATH <i>St. Louis, Mo.</i>		8. DATE OF DEATH <i>8/22/11</i>		9. TIME OF DEATH <i>10:15 PM</i>	
10. CAUSE OF DEATH <i>Scarlet fever</i>		11. DISEASE OR INJURY <i>Scarlet fever</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>James C. Taylor</i>		14. SIGNATURE OF WITNESS <i>Lawrence A. Ruffe MD.</i>		15. DATE <i>8/22/11</i>	
16. SIGNATURE OF REGISTRAR <i>[Signature]</i>		17. DATE <i>8/22/11</i>		18. TIME <i>10:15 PM</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11437 CERTIFICATE OF DEATH

Reg. Dist. No. 11433

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 1113 Nursing Home, Takoma Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>none</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 30-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Larkin</u>		14. MOTHER'S MAIDEN NAME <u>MARY MARIE SCHULTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1105 "G" ST. S.E.</u>	
17. INFORMANT <u>James A. Allen</u>		Address <u>1105 "G" ST. S.E. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> 450.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/3</u> , 19 <u>56</u> , to <u>10/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 1</u> , 19 <u>58</u> , and that death occurred at <u>12:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/8/58</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		M.D. <u>7701 Carroll Ave. Takoma Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>Washington D.C.</u>	
24a. REC'D BY REGISTRAR <u>OCT 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11438 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Delaware</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>				d. STREET ADDRESS <u>5603 Berks St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel (NMN) Allen</u>				4. DATE OF DEATH Month Day Year <u>October 15 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/87</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Groceryman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob Allen</u>				14. MOTHER'S MAIDEN NAME <u>Zeida (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium + Hosp. Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>33 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-14-58</u> , 19 <u>58</u> , to <u>10-15-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-14-58</u> , 19 <u>58</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park Md</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Rachael R. Clapp</u> M.D. <u>7600 Carroll Ave Takoma Park Md</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Jacobs Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Collingsdale, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Langensky</u>				ADDRESS <u>3501-14 St NW D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Div. No.

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15, 1900</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. RELIGION <i>Methodist</i>		10. EDUCATION <i>High School</i>		11. SOCIAL SECURITY NUMBER <i>123-45-6789</i>		12. DATE OF DEATH <i>Dec 10, 1945</i>		13. PLACE OF DEATH <i>Home</i>		14. CAUSE OF DEATH <i>Heart Disease</i>		15. MANNER OF DEATH <i>Natural</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>		19. SIGNATURE OF REGISTRAR <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11469

CERTIFICATE OF DEATH

11435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4708 Southern Avenue, SE	
3. NAME OF DECEASED (Type or print) First George Middle William Last Andree		4. DATE OF DEATH Month October Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1900
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Projectionist		10b. KIND OF BUSINESS OR INDUSTRY Movie Industry	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Andree		14. MOTHER'S MAIDEN NAME Etta McCord	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Staphylococcal Endocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia			
INTERVAL BETWEEN ONSET AND DEATH 39 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23 1958 to October 12, 1958 , that I last saw the deceased alive on October 12, 1958 , and that death occurred at 8:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James C. Kirby Jr. M.D.		DATE SIGNED 10-13-58	
PHYSICIAN'S NAME (Type) James C. Kirby, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/15/58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cem	22d. LOCATION (City, town, or county) (State) Calmar Manor, Md
23. FUNERAL DIRECTOR'S SIGNATURE G. Wm Lee's Sons Co		24a. REC'D BY REGISTRAR 1 4 '58	
ADDRESS 300 4th St N.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belknap Park</u>		c. LENGTH OF STAY in 1b <u>9 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>10012 Brackmoor Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Alice</u> Last <u>ARBOGAST</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-65</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LUTHER BOND</u>				14. MOTHER'S MAIDEN NAME <u>Unknown WOLFDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, MASSIVE</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>SKULL FRACTURE, LEFT FRONTO-PARIETO-SPHENOID</u> (a), stating the underlying cause last. DUE TO (c) <u>11</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>10-6</u> p.m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Notural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brusch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCH, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. & burial 10/10/58</u>		22b. DATE THEREOF <u>10/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CLARKSBURG, WEST VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 9 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11470 CERTIFICATE OF DEATH

Reg. Dist. No.

11437

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 10 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia p. COUNTY Payette		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Summerlee		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS P.O.Box 113		4. DATE OF DEATH Month October Day 15th, Year 1958							
3. NAME OF DECEASED (Type or print) Larry		First Wayne		Middle Baber		Last		4. DATE OF DEATH Month October Day 15th, Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29th, 1950		9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min. 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Earl K. Baber		14. MOTHER'S MAIDEN NAME Dorothy Burgess									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 7540 DUE TO (b) pulmonary insufficiency (respiratory insufficiency) DUE TO (c) Immediate post-operative correction of Tetralogy of Fallot & Atrial septal defect PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Conquited heart lesion		INTERVAL BETWEEN ONSET AND DEATH 10/15/58									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from October 5, 1958 , to October 15, 1958 , that I last saw the deceased alive on October 15th, 1958 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above.											
ACTUAL SIGNATURE U. Perryman Collins		M.D. The Clinical Center		ADDRESS (Street, city or town, state) The National Institutes of Health		DATE SIGNED 10/15/58					
PHYSICIAN'S NAME (Type) N. Perryman Collins, M.D.											
22a. JOURNAL OF CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/15/58		22c. NAME OF CEMETERY OR CREMATORY Oak Hill, W. Virginia		22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR DATE OCT 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11471

CERTIFICATE OF DEATH

Reg. Dist. No. 11438

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Nursing Home				d. STREET ADDRESS 5525 Graystone Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HUGO Middle BACHARACH Last BACHARACH				4. DATE OF DEATH Month October Day 29 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872		9. AGE (In years lost birthday) yrs. 86	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Meat Dealer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frankfort, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Bacharach				14. MOTHER'S MAIDEN NAME Johanna Marx			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Mr. Joseph P. Dratch - 5525 Graystone St., Ch.Ch., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 30 days - 15 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Insufficiency - Ceptotomy on Oct 11, 1958.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 1953 to Oct 29, 1958 , that I last saw the deceased alive on Oct. 28, 1958 , and that death occurred at 230 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Dessoiff		M.D. 1302-188th H. Wash DC		ADDRESS (Street, city or town, state)		DATE SIGNED 10/29/58	
PHYSICIAN'S NAME (Type) SAMUEL DESSOFF							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-58		22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., NW				24a. REC'D BY REGISTRAR NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur J. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11472

CERTIFICATE OF DEATH

11439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tennessee</u> b. COUNTY <u>Johnson City</u> 79X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>259 W. Market Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Lee</u> Last <u>Bacon</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1936</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dental Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Elmer R. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Hodge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible Hypotension</u> <u>648.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intraabdominal Hemorrhage</u> DUE TO (c) <u>Chorioadenoma Desecans</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>3 days.</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deposits - possibly toxic</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>10</u> Day <u>4</u> Year <u>1958</u> a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 18, 1958</u> , to <u>October 4, 1958</u> , that I last saw the deceased alive on <u>October 18, 1958</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald A. Kellogg</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
DATE SIGNED <u>10-4-58</u>			
PHYSICIAN'S NAME (Type) <u>Donald A. Kellogg, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sulphur Springs</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co., Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

11473

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS Route #3, Box 539 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Max BAUER		4. DATE OF DEATH Month Day Year October 23 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 28, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick BAUER		14. MOTHER'S MAIDEN NAME Louise CLAUS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. None	
17. INFORMANT (W) Mrs. Flora S. Bauer, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma stomach with metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 28 , 19 58 , to Oct. 23 , 19 58 , that I lost saw the deceased alive on Oct. 23 , 19 58 , and that death occurred at 3:10A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 10-23-58			
ACTUAL SIGNATURE W. D. Hooper		M.D. U. S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) W. D. HOOPER, LT MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd, Arlington,		24a. REC'D BY REGISTRAR OCT 27 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

<p>1. Name of deceased (Print name and last name) _____</p>		<p>2. Sex _____</p>		<p>3. Age _____</p>	
<p>4. Date of death _____</p>		<p>5. Time of death _____</p>		<p>6. Place of death _____</p>	
<p>7. Cause of death (State immediately preceding cause) _____</p>		<p>8. Manner of death (State whether natural, accidental, suicide, homicide, or undetermined) _____</p>		<p>9. Signature of physician (Print name and last name) _____</p>	
<p>10. Signature of registrar (Print name and last name) _____</p>		<p>11. Signature of medical examiner (Print name and last name) _____</p>		<p>12. Signature of coroner (Print name and last name) _____</p>	
<p>13. Signature of funeral director (Print name and last name) _____</p>		<p>14. Signature of undertaker (Print name and last name) _____</p>		<p>15. Signature of other person (Print name and last name) _____</p>	

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 JAN 10 1968

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 JAN 10 1968

11474 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,504 NEWPORT MILL ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle L Last BEALL				4. DATE OF DEATH Month OCTOBER Day 11 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/01	
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Pa. Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank E. Beall				14. MOTHER'S MAIDEN NAME Mary F. McFarland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Mildred E. Beall, 11504 Newport Mill Rd. Silver Spring, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary + thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1958 to October 11, 1958 that I last saw the deceased alive on October 11, 1958 and that death occurred at 4:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12020 Morgan Way, Washington, D.C. DATE SIGNED 10/11/58							
ACTUAL SIGNATURE Patrick J. Jameson M.D.				PHYSICIAN'S NAME (Type) P. C. JAMESON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11/14/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND							
23. BURIAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond A. Zisker				24a. REC'D BY REGISTRAR Oct 14 58		24b. REGISTRAR'S SIGNATURE Arthur A. Thoms	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11475 CERTIFICATE OF DEATH

Reg. Dist. No.

11442

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5305 Chamberlain St.		d. STREET ADDRESS 5305 Chamberlain St.	
3. NAME OF DECEASED (Type or print) First George Middle Lewis Last Bell		4. DATE OF DEATH Month October Day 9 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY New Mexico	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Neil Bell		14. MOTHER'S MAIDEN NAME Susan Woolfolk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 225-10-1028	
17. INFORMANT Rachel S. Bell		Address 5305 Chamberlain St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-3 , 19 44 to 10-9 , 19 58 , that I last saw the deceased alive on 10-8 , 19 58 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter K. Myers M.D.		DATE SIGNED Washington 10-8	
PHYSICIAN'S NAME (Type) Walter K. Myers		ADDRESS 3011 45th Street, N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur & Rem		22b. DATE THEREOF 10/11/58	
22c. NAME OF CEMETERY OR CREMATORY 1756 Penna. Av. NW		22d. LOCATION (City, town, or county) (State) Potosi Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lewis's Son		24a. REC'D BY REGISTRAR OCT 14 '58	
ADDRESS 1756 Penna. Av. NW		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Jan 1, 1900		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Place of Birth		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
New York		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Age at Death		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
50 years		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Date of Death		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Jan 15, 1950		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Time of Death		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
10:00 AM		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Signature of Physician		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
J. Smith		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Signature of Registrar		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
A. Jones		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	
Signature of Informant		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
B. Brown		Jan 15, 1950		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		Home		Jan 15, 1950		10:00 AM		J. Smith		A. Jones		B. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11476 CERTIFICATE OF DEATH

11443
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>Philadelphia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Philadelphia</i> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Rest Home</i>		d. STREET ADDRESS <i>5327 Baynton St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Bertha</i> Middle <i>Bennett</i> Last <i>Bennett</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1, 1877</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR: Months <i>10</i> Days <i>5</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>	
11. BIRTHPLACE (State or foreign country) <i>M. J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Alphonza Bennett</i>		14. MOTHER'S MAIDEN NAME <i>Mary Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Mary B. Old, 6629 33rd St. S.W.</i>		Address <i>Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>8/1</i> , 19 <i>58</i> , to <i>10/6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/1</i> , 19 <i>58</i> , and that death occurred at <i>1:25 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Allen J. O'Neill</i> M.D.		ADDRESS (Street, city or town, state) <i>8601 Old Georgetown Rd</i> DATE SIGNED <i>MS</i>	
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		<i>Bethesda</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/10/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cold Springs Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Cape May, New Jersey</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>		24a. REC'D BY REGISTRAR <i>Bethesda, Maryland</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11464 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 W. Montgomery Avenue				d. STREET ADDRESS 318 W. Montgomery Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle ADELE Last BENNETT				4. DATE OF DEATH Month October Day 9 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1873		9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months 0 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Bennett				14. MOTHER'S MAIDEN NAME Ema Mays Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lillian A. Bennett-sister-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Emopia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 days Indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x Bronchopneumonia & Fracture of rt. hip							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7/28 , 19 58 , to 10/9 , 19 58 , that I last saw the deceased alive on 10/9 , 19 58 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md		DATE SIGNED 10/10/58	
PHYSICIAN'S NAME (Type) Stephen N. Jones				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/58		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Burtonsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR Oct 14 '58	
				24b. REGISTRAR'S SIGNATURE Robert L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

COUNTY OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	
NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 45 Years		DATE OF BIRTH Jan 15, 1885	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Single		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Jan 25, 1930		TIME OF DEATH 10:30 AM	
PLACE OF DEATH Home		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF REGISTRAR (None)	

This certificate is to be filled out by the physician or coroner in charge of the case. It should be filled out as soon as possible after the death, and should be filed in the office of the Registrar of the Department of Health. The Registrar will issue a certificate of death to the family of the deceased, and will also issue a certificate of death to the family of the deceased. The Registrar will also issue a certificate of death to the family of the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22d Film 235 10-24-58 et

CERTIFICATE OF DEATH

11445

11477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10410 Gatewood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>MARIE</u> Middle <u>ANNA</u> Last <u>Bergmeyer</u>		4. DATE OF DEATH		Month <u>Oct.</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27 1896</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GAGE CO. NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George D. Sykes</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA THUMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Vernita Bergmeyer 10710 Gatewood Rd. Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Adeno Carcinoma</u> DUE TO (c) <u>Adeno Carcinoma - Primary in Breast</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u> <u>1 MONTH</u> <u>7 MONTHS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1</u> , 19 <u>58</u> , to <u>Oct. 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-20</u> , 19 <u>58</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1515 E. FRIKLAND RD. S.S. Md.</u> DATE SIGNED <u>Oct 20, 1958</u>							
ACTUAL SIGNATURE <u>Robert H. Craft</u>				PHYSICIAN'S NAME (Type) <u>ROBERT H. CRAFT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>OCT. 22, 1958</u>		<u>EVERGREEN HOME CEMETERY</u>		<u>BEATRICE, GAGE CO., NEBRASKA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Raymond C. Ziska</u>				<u>OCT 21 '58</u>		<u>Arthur J. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 12

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE

TIME

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

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11478 CERTIFICATE OF DEATH

11446

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Eaton Town</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eaton Town</u> 67x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>River Dale Farm</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Crispin Bernard</u>				4. DATE OF DEATH Month Day Year <u>Oct 27 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 24 1879</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>David Crispin</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>J. L. Bernard 440 Riverdale Ave. Eatontown, N. J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Atrio Sclerotic Heart Disease</u> DUE TO <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis</u> DUE TO (c) <u>Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 2 - 1957</u> to <u>10-27-1958</u> , that I last saw the deceased alive on <u>7-30-1958</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.W. Bird</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring 10/27/58</u>			
PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>				Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11440 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1mth +</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dorothy Hill Bibbs</u>				4. DATE OF DEATH <u>October 4 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Minn.</u>	
13. FATHER'S NAME <u>Clarence Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Phlebotrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Myocardial infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 + 4 days</u> <u>10 - 14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>9/28/58</u> , 19 <u>58</u> , to <u>10/3/58</u> , that I last saw the deceased alive on <u>9/28/58</u> , 19 <u>58</u> , and that death occurred at <u>3:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. H. Wolohun</u>				ADDRESS (Street, city or town, state) <u>WASHINGTON SANITARIUM, TAKOMA PARK, MD</u>			
DATE SIGNED <u>10/4/58</u>				M.D. <u>WASHINGTON SANITARIUM, TAKOMA PARK, MD</u>			
PHYSICIAN'S NAME (Type) <u>CHAS. H. WOLOHUN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elizabeth, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>25 Carroll St. N.W. Wash 12, D.C.</u>				DATE <u>OCT 6 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11479 CERTIFICATE OF DEATH

Reg. Dist. No.

11448

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 8-12-58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS Apt 432 1601 Argonne Place N.W.			
3. NAME OF DECEASED (Type or print) First Belle Middle Bassett Last Blackley				4. DATE OF DEATH Month 10 Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-28-1865	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Texas				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Robert Bassett				14. MOTHER'S MAIDEN NAME Sarah Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Nursing home records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 hrs 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 58 to 4 Oct 19 58 , that I last saw the deceased alive on 4 Oct 19 58 , and that death occurred at 10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Massie Page M.D.				ADDRESS (Street, city or town, state) 1150 Conn. Ave. 4 Oct 19 58			
DATE SIGNED 4 Oct 19 58				PHYSICIAN'S NAME (Type) R. MASSIE PAGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/7/58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. Wash, D.C. N.W.				24a. REC'D BY REGISTRAR OCT 8 58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11480 CERTIFICATE OF DEATH

11449
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 50 min.				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Virginia b. COUNTY Arlington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 904 S. Orme Street			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Houston BLAIR			4. DATE OF DEATH Month Day Year October 24 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-58		9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR Months Days Hours Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Charles BLAIR				14. MOTHER'S MAIDEN NAME Della Catherine MOOG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Robt. C. Blair, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 762.0 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 1958 , to October 24, 1958 , that I last saw the deceased alive on October 24, 1958 , and that death occurred at 1:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth W. Sell M.D.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 10-24-58	
PHYSICIAN'S NAME (Type) Kenneth W. SELL, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington, VA				24a. REC'D BY REGISTRAR OCT 27 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11481 CERTIFICATE OF DEATH

11450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Louis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				e. STREET ADDRESS <u>SILVER SPRING MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BARNETT</u> Last <u>BLUM</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1-1874</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Beryl</u>				14. MOTHER'S MAIDEN NAME <u>Serna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-52-7206A</u>		17. INFORMANT <u>Morris Blum Silver Spring</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS UNDERLYING: IMMEDIATE CAUSE (a) <u>CEREBRO-VASC. THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL & GEN. ATHEROSCLEROSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>JUN</u> _____, 19 <u>57</u> , to <u>Oct. 31</u> _____, 19 <u>58</u> that I last saw the deceased alive on <u>Oct. 29</u> _____, 19 <u>58</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack J. Rheingold</u> M.D.				ADDRESS (Street, city or town, state) <u>1302 18th St. NW.</u>		DATE SIGNED <u>10/31/58</u>	
PHYSICIAN'S NAME (Type) <u>JACK J. RHEINGOLD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 2-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Lebanon Cem</u>		22d. LOCATION (City, town or county) (State) <u>Hyattsville MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg</u> ADDRESS <u>4217-9th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. HARRIS		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 10/15/1912		5. PLACE OF BIRTH NEW YORK		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. NAME OF SPOUSE MARY J. HARRIS		9. DATE OF MARRIAGE 1935		10. PLACE OF MARRIAGE NEW YORK		11. NAME OF DECEASED'S FATHER JOHN J. HARRIS		12. NAME OF DECEASED'S MOTHER MARY J. HARRIS	
13. DATE OF DEATH 10/25/1957		14. TIME OF DEATH 10:30 PM		15. PLACE OF DEATH HOME		16. CAUSE OF DEATH HEART DISEASE		17. MANNER OF DEATH NATURAL		18. SIGNATURE OF PHYSICIAN DR. J. H. HARRIS	
19. SIGNATURE OF DECEASED'S NEXT OF KIN MARY J. HARRIS		20. ADDRESS OF DECEASED'S NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD.		21. SIGNATURE OF DECEASED'S NEXT OF KIN MARY J. HARRIS		22. ADDRESS OF DECEASED'S NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD.		23. SIGNATURE OF DECEASED'S NEXT OF KIN MARY J. HARRIS		24. ADDRESS OF DECEASED'S NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD.	
25. SIGNATURE OF DECEASED'S NEXT OF KIN MARY J. HARRIS		26. ADDRESS OF DECEASED'S NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD.		27. SIGNATURE OF DECEASED'S NEXT OF KIN MARY J. HARRIS		28. ADDRESS OF DECEASED'S NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD.		29. SIGNATURE OF DECEASED'S NEXT OF KIN MARY J. HARRIS		30. ADDRESS OF DECEASED'S NEXT OF KIN 1234 E. MAIN ST. BALTIMORE, MD.	

10-10-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11451

11482 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince Edward	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 35 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ieni Middle (H) Last Boggs		4. DATE OF DEATH Month October Day 7 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Rohrabough		14. MOTHER'S MAIDEN NAME Mary Sipe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X CARCINOMATOSIS FROM CARCINOMA OF CERVIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PAROTITIS SUPPURATIVE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 19	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 2, 1958 , to October 7, 1958 , that I last saw the deceased alive on October 7, 1958 , and that death occurred at 12:53A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/7/58			
ACTUAL SIGNATURE James M. Marsh M.D.		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) James M. Marsh, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/8/58		22b. DATE THEREOF 10/8/58	
22c. NAME OF CEMETERY OR CREMATORY Alderson Cemetery		22d. LOCATION (City, town, or county) (State) Alderson, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11452

11483 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4307 Elm. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE.</u> <u>Florence</u> <u>BOWEN</u>				4. DATE OF DEATH Month Day Year <u>October</u> <u>7</u> <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Stafford Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Stafford Co., Virginia</u>	
13. FATHER'S NAME <u>Mace Perkins</u>				14. MOTHER'S MAIDEN NAME <u>Marion Wallace Monteith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son</u> <u>C. Lee Bowen</u> Address <u>5419 Roosevelt St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION.</u> DUE TO (c) <u>HYPERTENSIVE HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> <u>2 HRS.</u> <u>20 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>6/23</u> 19 <u>53</u> , to <u>10/7</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/7</u> 19 <u>58</u> , and that death occurred at <u>11:58 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D. <u>9300 Ewing Drive Bethesda, Md. 10/7/58</u> PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Niles Co. 2901-14th St. N. W.</u>				24a. REC'D BY REGISTRAR <u>Oct 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Frank</u>	

11484 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.			
3. NAME OF DECEASED (Type or print) THALES First BOWEN Middle BOWEN Last				4. DATE OF DEATH OCT. 15 19 58 Month 15 Day 19 Year 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/5/85	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS I. BOWEN				14. MOTHER'S MAIDEN NAME ANNIE BELLE BOWEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Dr. Thales Bowen Jr. Address 405 Parkview Dr. Wynnwood, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebra, terminal 420.1 DUE TO nephrosclerosis, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior sclerosis, generalized (c) Myocardial Infarction, posterior lateral wall 7 days old							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction, posterior lateral wall 7 days old							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1958 to Oct 15 1958 , that I last saw the deceased alive on Oct 15 1958 , and that death occurred at 10:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp				ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash D.C.			
DATE SIGNED Oct 15 1958							
PHYSICIAN'S NAME (Type) Stewart Clapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Christine S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11485 CERTIFICATE OF DEATH

11454

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Virginia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 38 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNMHC				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Ellen Fouts BOWMAN				4. DATE OF DEATH Month Day Year October 15 1958					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-15			
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Florida			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Edwin Lewis FOUTS				14. MOTHER'S MAIDEN NAME Mary DENHAM					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (Husb) George S. Bowman, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of rectum and</u> DUE TO (c) <u>Carcinoma of breast</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from September 8, 1958, to October 15, 1958, that I last saw the deceased alive on October 14, 1958, and that death occurred at 5:25A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>M. G. Mitts</u>				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMHC		DATE SIGNED 10-15-58			
PHYSICIAN'S NAME (Type) M. G. MITTS, LT, MC, USN				Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold L. Summer</u> Cunningham Funeral Home, Cameron & Alfred Sts.,				ADDRESS Alexandria, Va.		24a. REC'D BY REGISTRAR DATE OCT 16 '58			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11486

CERTIFICATE OF DEATH

11455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>		d. STREET ADDRESS <u>2501 QUE ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Viola</u> Last <u>BOYLAND</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 3, 1875</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P.H. WILMERTON</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Records at Nursing Home-Kensington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis (with small multiple thromboses)</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25, 1958</u> , to <u>Oct. 24, 1958</u> , that I last saw the deceased alive on <u>Oct 19, 1958</u> , and that death occurred at <u>8:20</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warner D. Brill, M.D.</u>		DATE SIGNED <u>Oct 24, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Warner D. Brill, M.D.</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Peace Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. H. Hines, Jr., Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DACT 27 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11487

CERTIFICATE OF DEATH

Reg. Dist. No. 11456

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 69 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gordon Bell Bradley				4. DATE OF DEATH Month Day Year October 20, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 3, 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer				10b. KIND OF BUSINESS OR INDUSTRY Photography		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph S. Bradley				14. MOTHER'S MAIDEN NAME Landora Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STAPHYLOCOCCAL SEPTICEMIA 154X DUE TO THROMBOPHLEBITIS OF RT LEG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA of the RECTUM DUE TO GENERALIZED Metastases (c) GENERALIZED Metastases INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 12, 1958 , to October 20, 1958 , that I last saw the deceased alive on October 20, 1958 , and that death occurred at 3:25 PM , from the causes and on the date stated above							
ACTUAL SIGNATURE James M. Marsh M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) James M. Marsh, M. D.				DATE SIGNED 10/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-21-58		22c. NAME OF CEMETERY OR CREMATORY Lees Crematorium		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee's Sons Co.				ADDRESS 300-4th at NE		24a. REC'D BY REGISTRAR DATE OCT 23 '58	
				24b. REGISTRAR'S SIGNATURE C. S. Kneel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11158

CERTIFICATE OF DEATH

11158

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Wm. A. T. 11158

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Place of Report	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11457

Reg. Dist. No.

11488

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 yrs</u> <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4612 Coakway Dr.</u>		d. STREET ADDRESS <u>4612 Coakway Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine Cecelia Bready</u>		4. DATE OF DEATH <u>10-19-58</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-90</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MULVIHILL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret Gore - Same as Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-19-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins 3821-14th N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 21 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
EARTH FILE

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. PRESENT ADDRESS: _____

9. DATE OF DEATH: _____

10. PLACE OF DEATH: _____

11. CAUSE OF DEATH: _____

12. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

13. SIGNATURE OF MEDICAL EXAMINER: _____

14. SIGNATURE OF WITNESS: _____

15. SIGNATURE OF CORONER: _____

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE EARTH FILE, BALTIMORE, MD.

TO BE FILED IN THE OFFICE OF THE STATE EARTH FILE, BALTIMORE, MD.

TO BE FILED IN THE OFFICE OF THE STATE EARTH FILE, BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11489 CERTIFICATE OF DEATH

11458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 18 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville d. STREET ADDRESS 14 Williams St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nicholas --- , Brewer		4. DATE OF DEATH Month Day Year October 20 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/84
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days 6 29	IF UNDER 24 HRS. Hours Min. 19 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Financiere		10b. KIND OF BUSINESS OR INDUSTRY Dunn and Bradstreet	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME John B. Brewer		14. MOTHER'S MAIDEN NAME Virginia Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal Ulcer - 4 hrs. post-operative			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15, 1958 , to 10/20, 1958 , that I last saw the deceased alive on 10/19, 1958 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 10/22/58			
ACTUAL SIGNATURE Arthur F. Woodward M.D.		PHYSICIAN'S NAME (Type) A. F. Woodward, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/58	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11459	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b D.O.A.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights d. STREET ADDRESS 6112 Namakagan Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Henry Middle Hermann Last Buckholtz					4. DATE OF DEATH Month October Day 12 Year 1958						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1900		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver					10b. KIND OF BUSINESS OR INDUSTRY Taxicab Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Hermann Theodore Buckholtz					14. MOTHER'S MAIDEN NAME Wilhemina Buckholtz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Margaret A. Buckholtz		Address 6112 Namakagan Rd. Glen Echo Hgts., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon monoxide poisoning DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH Found dead in auto	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hose attached to exhaust extending in car									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Glen Echo Hts. Montg. Md.					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschert					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. Broschert					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					10-12-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer Va.					
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.					ADDRESS 3012 M. ST. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks		

11491 CERTIFICATE OF DEATH

Reg. Dist. No. 11460

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>120 Center Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Infant Boy</u> First Middle Last <u>BUTLER</u>				4. DATE OF DEATH <u>October 13</u> 19 <u>58</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 8th 1958</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ROBERT NEIL BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>DIANE THERESA McLAUGHLIN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEGMENTAL ATELECTASIS</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 8th 1958</u> to <u>October 13 1958</u> , that I last saw the deceased alive on <u>October 13th 1958</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>OCT 13 1958</u>							
ACTUAL SIGNATURE <u>Ira W. Pearlman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Ira W. Pearlman -4700 Bradley Blvd.-Chevy Chase.Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

2074294XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1002

11492 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 14212 Brookfield Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James Ellsworth Butler				4. DATE OF DEATH Month October Day 24 Year 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1911		9. AGE (In years lost birthday) 47 yrs.	IF UNDER 1 YEAR Months 1 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker			10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal Ind.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph A. Butler				14. MOTHER'S MAIDEN NAME Isabel PMH Weaver			
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) yes World War II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Rita Eleanor Butler--Wife--same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema due to anoxia							1 day
141.9 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) following hemorrhage from							3 days
(c) Recurrent Squamous Carcinoma of Tongue							2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 10/24, 1958 , to 10/24, 1958 , that I last saw the deceased alive on 10/24, 1958 , and that death occurred at 4 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frederick Y. Donn				ADDRESS (Street, city or town, state) 1835 E St., N.W. Wash, D.C.			
DATE SIGNED 10/28/58							
PHYSICIAN'S NAME (Type) Frederick Y. Donn, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 28 58	
				24b. REGISTRAR'S SIGNATURE Carroll S. [illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11493 CERTIFICATE OF DEATH

11462

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 4709 S. Chelsea Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LINDA First ARLINE Middle BUTLER Last				4. DATE OF DEATH Oct. 4, Month 19 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1949	
9. AGE (In years lost birthday) 9 yrs.		IF UNDER 1 YEAR 8 Months 4 Days		IF UNDER 24 HRS. 4 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin T. Butler				14. MOTHER'S MAIDEN NAME Donna Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Benjamin T. Butler - Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 277x Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Albright's Disease DUE TO (c) From birth						INTERVAL BETWEEN ONSET AND DEATH 2-3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/29 , 19 58 , to 10/14 , 19 58 , that I last saw the deceased alive on 10/3 , 19 58 , and that death occurred at 5:10 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 8218 - Wise Ave Bethesda Md				DATE SIGNED Beth Md			
ACTUAL SIGNATURE Vincent L. O'Donnell M.D.							
PHYSICIAN'S NAME (Type) Vincent L. O'Donnell, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland ADDRESS				24a. REC'D BY REGISTRAR OCT 7 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIANO STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11494 CERTIFICATE OF DEATH

11463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Genevieve Cassidy		4. DATE OF DEATH Month Day Year October 31 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dance Instructor		10b. KIND OF BUSINESS OR INDUSTRY Musical	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bradford McMichael		14. MOTHER'S MAIDEN NAME Mary Hass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) fibrous adhesions DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 72 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Heart Disease--atrial septal defect			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Washington		(County) (State)	
21. I certify that I attended the deceased from October 22, 1958 , to October 31, 1958 , that I last saw the deceased alive on October 31, 1958 , and that death occurred at 12:46 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon I. Goldberg		M.D. The Clinical Center ADDRESS (Street, city or town, state) 10-31-58 DATE SIGNED	
PHYSICIAN'S NAME (Type) Leon I. Goldberg, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) 11-3-1958	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawler's Sons, Wash., D.C.		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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11495

CERTIFICATE OF DEATH

Reg. Dist. No. 11464

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
c. LENGTH OF STAY IN 1b 18 mo.		d. STREET ADDRESS 8007 Takoma Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8007 Takoma Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alonzo Middle John Last Chadsey		4. DATE OF DEATH Month October Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1872
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. Secretary		10b. KIND OF BUSINESS OR INDUSTRY Met. Life Ins. Co.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonzo John Chadsey		14. MOTHER'S MAIDEN NAME Marie Emily Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Beatrice Kelly-8007 Takoma Ave. S.S.Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma of Right Lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastasis to Liver (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1958 , to October 4, 1958 , that I last saw the deceased alive on October 1, 1958 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Russell B. Arnold M.D.		ADDRESS (Street, city or town, state) 8801 Colesville Road, DATE SIGNED	
PHYSICIAN'S NAME (Type) Russell B. Arnold M.D. Silver Spring, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10/4/58	22c. NAME OF CEMETERY OR CREMATORY Blue Mountain	22d. LOCATION (City, town, or county) (State) Saugerties, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. Washington		24a. REC'D BY REGISTRAR DATE OCT 6 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11465

CERTIFICATE OF DEATH

11465

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 26 d. NAME OF HOSPITAL (If not in hospital, give street address) 11509 Danville Drive				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 11509 Danville Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) JOHN A. CLARK First Middle Last				4. DATE OF DEATH Oct. 8, 1958 Month Day Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jne 10, 1898		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 3 Days 28		IF UNDER 24 HRS. Hours 19 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Operator				10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit				11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME John F. Clark						14. MOTHER'S MAIDEN NAME Belle McCadden									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWI				16. SOCIAL SECURITY NO. 578-10-5574		17. INFORMANT Arline E. Clark-Item # 2 Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH known 15 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension - known 4 years														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/3 , 19 54 , to Oct , 19 58 that I last saw the deceased alive on Oct Sept 24, 1958 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED															
ACTUAL SIGNATURE Allen J. O'Neill M.D.															
PHYSICIAN'S NAME (Type) Allen J. O'Neill 8601 Old Georgetown Road, Bethesda, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) (State) Arlington, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. ADDRESS								24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11496 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WASH, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 8	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		d. NAME OF HOSPITAL (If not in hospital, give street address) SUBURBAN	
d. STREET ADDRESS 3726 JOCELYN ST., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle E Last COCHRANE		4. DATE OF DEATH Month 10 Day 17 Year 1958	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/85
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. -		10b. KIND OF BUSINESS OR INDUSTRY US Govt.	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John E. Cochran		14. MOTHER'S MAIDEN NAME Anne Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harriet H. Cochran-Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subendocardial Infarction, Left Ventricle 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis, Left Anterior Circulus Artery DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Govt. moderately severe 2) Myocardial Infarction 1956			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , to Oct 17 , 1958, that I last saw the deceased alive on Oct 17 , 1958, and that death occurred at 12:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St NW Wash DC DATE SIGNED Oct 17 58			
ACTUAL SIGNATURE Stewart Clapp M.D.		DATE SIGNED Oct 17 58	
PHYSICIAN'S NAME (Type) Stewart Clapp		ADDRESS Wash DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/20/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitlane, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 20 58	
24b. REGISTRAR'S SIGNATURE William S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11497 CERTIFICATE OF DEATH

11467

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 36 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 4000 Massachusetts Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claiborn Middle J. Last COCKRELL		4. DATE OF DEATH Month October Day 29 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58	11. IF UNDER 24 HRS. Days 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses COCKRELL		14. MOTHER'S MAIDEN NAME Sarah OWENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 547-36-6430	
17. INFORMANT (W) Lucille M. Cockrell, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Generalized arteriosclerosis DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction due to coronary thrombosis 5 weeks INTERVAL BETWEEN ONSET AND DEATH 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 23, 1958 , to October 29, 1958 , that I lost sow the deceased olive on October 29, 1958 , and that death occurred at 10:55P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. T. Horgan		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM	
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		DATE SIGNED 10-30-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey		24. REC'D BY REGISTRAR Nov 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Horgan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

$$\left(\frac{1}{2} - \frac{1}{2} \right) = 0$$

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

COPIES OF THE

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11441

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) 75 WASH KINGTON SANITARIUM + HOSPITAL				d. STREET ADDRESS 3919 Kincaid Tr.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Isabella FRANCES Cole				4. DATE OF DEATH 10 9 58			
5. SEX FE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/26/25	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker				10b. KIND OF BUSINESS OR INDUSTRY Mont. County Welfare		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Leo J. Gossman				14. MOTHER'S MAIDEN NAME Gertrude Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 357-18-2217		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 330x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital cerebral arterial aneurysmal rupture (c) 32 yrs				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 7 , 19 58 , to Oct. 9 , 19 58 , that I last saw the deceased alive on Oct. 9 , 19 58 , and that death occurred at 4 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave., Silver Spring, Md. DATE SIGNED 10/10/58							
ACTUAL SIGNATURE Donald Nelson				M.D. 10620 Georgia Ave., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Donald Nelson							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/13/58		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE OCT 14 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11469

Reg. Dist. No.

11468

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Lincoln Park - Rockville</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>308 Stonestreet Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mabel</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> - Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-1917</u> 9. AGE (In years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Augustus Williams</u>		14. MOTHER'S MAIDEN NAME <u>Lula Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>954X</u>	
17. INFORMANT <u>Husband William Cook</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>385X</u> DUE TO (b) <u>Status Post Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>7 hours</u> <u>7 hours</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Supine extraction, cataract left eye, general anesthesia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>954X</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-10-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11158

11158

NAME OF DECEASED *John Doe*
RESIDENCE *123 Main St, Baltimore, Md*
AGE *45* SEX *M*
DATE OF DEATH *Jan 15, 1924*
PLACE OF DEATH *Home*
CAUSE OF DEATH *Myocardial Infarction*
MANNER OF DEATH *Natural*
SIGNATURE OF EXAMINER *J. H. Smith*
TITLE *Medical Examiner*

1. CHIEF CAUSE OF DEATH	
2. SECOND CAUSE OF DEATH	
3. THIRD CAUSE OF DEATH	
4. OTHER CAUSE OF DEATH	
5. MANNER OF DEATH	
6. SIGNATURE OF EXAMINER	
7. TITLE OF EXAMINER	
8. DATE OF EXAMINATION	
9. PLACE OF EXAMINATION	
10. NAME OF DECEASED	
11. RESIDENCE OF DECEASED	
12. AGE OF DECEASED	
13. SEX OF DECEASED	
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17. MANNER OF DEATH	
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259. TITLE OF EXAMINER	
260. DATE OF EXAMINATION	
261. PLACE OF EXAMINATION	
262. NAME OF DECEASED	
263. RESIDENCE OF DECEASED	
264. AGE OF DECEASED	
265. SEX OF DECEASED	
266. DATE OF DEATH	
267. PLACE OF DEATH	
268. CAUSE OF DEATH	
269. MANNER OF DEATH	
270. SIGNATURE OF EXAMINER	
271. TITLE OF EXAMINER	
272. DATE OF EXAMINATION	
273. PLACE OF EXAMINATION	
274. NAME OF DECEASED	
275. RESIDENCE OF DECEASED	
276. AGE OF DECEASED	
277. SEX OF DECEASED	
278. DATE OF DEATH	
279. PLACE OF DEATH	
280. CAUSE OF DEATH	
281. MANNER OF DEATH	
282. SIGNATURE OF EXAMINER	
283. TITLE OF EXAMINER	
284. DATE OF EXAMINATION	
285. PLACE OF EXAMINATION	
286. NAME OF DECEASED	
287. RESIDENCE OF DECEASED	
288. AGE OF DECEASED	
289. SEX OF DECEASED	
290. DATE OF DEATH	
291. PLACE OF DEATH	
292. CAUSE OF DEATH	
293. MANNER OF DEATH	
294. SIGNATURE OF EXAMINER	
295. TITLE OF EXAMINER	
296. DATE OF EXAMINATION	
297. PLACE OF EXAMINATION	
298. NAME OF DECEASED	
299. RESIDENCE OF DECEASED	
300. AGE OF DECEASED	
301. SEX OF DECEASED	
302. DATE OF DEATH	
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304. CAUSE OF DEATH	
305. MANNER OF DEATH	
306. SIGNATURE OF EXAMINER	
307. TITLE OF EXAMINER	
308. DATE OF EXAMINATION	
309. PLACE OF EXAMINATION	
310. NAME OF DECEASED	
311. RESIDENCE OF DECEASED	
312. AGE OF DECEASED	
313. SEX OF DECEASED	
314. DATE OF DEATH	
315. PLACE OF DEATH	
316. CAUSE OF DEATH	
317. MANNER OF DEATH	
318. SIGNATURE OF EXAMINER	
319. TITLE OF EXAMINER	
320. DATE OF EXAMINATION	
321. PLACE OF EXAMINATION	
322. NAME OF DECEASED	
323. RESIDENCE OF DECEASED	
324. AGE OF DECEASED	
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326. DATE OF DEATH	
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328. CAUSE OF DEATH	
329. MANNER OF DEATH	
330. SIGNATURE OF EXAMINER	
331. TITLE OF EXAMINER	
332. DATE OF EXAMINATION	
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335. RESIDENCE OF DECEASED	
336. AGE OF DECEASED	
337. SEX OF DECEASED	
338. DATE OF DEATH	
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340. CAUSE OF DEATH	
341. MANNER OF DEATH	
342. SIGNATURE OF EXAMINER	
343. TITLE OF EXAMINER	
344. DATE OF EXAMINATION	
345. PLACE OF EXAMINATION	
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347. RESIDENCE OF DECEASED	
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349. SEX OF DECEASED	
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352. CAUSE OF DEATH	
353. MANNER OF DEATH	
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355. TITLE OF EXAMINER	
356. DATE OF EXAMINATION	
357. PLACE OF EXAMINATION	
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359. RESIDENCE OF DECEASED	
360. AGE OF DECEASED	
361. SEX OF DECEASED	
362. DATE OF DEATH	
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364. CAUSE OF DEATH	
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367. TITLE OF EXAMINER	
368. DATE OF EXAMINATION	
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378. SIGNATURE OF EXAMINER	
379. TITLE OF EXAMINER	
380. DATE OF EXAMINATION	
381. PLACE OF EXAMINATION	
382. NAME OF DECEASED	
383. RESIDENCE OF DECEASED	
384. AGE OF DECEASED	
385. SEX OF DECEASED	
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388. CAUSE OF DEATH	
389. MANNER OF DEATH	
390. SIGNATURE OF EXAMINER	
391. TITLE OF EXAMINER	
392. DATE OF EXAMINATION	
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394. NAME OF DECEASED	
395. RESIDENCE OF DECEASED	
396. AGE OF DECEASED	
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398. DATE OF DEATH	
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401. MANNER OF DEATH	
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403. TITLE OF EXAMINER	
404. DATE OF EXAMINATION	
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411. PLACE OF DEATH	
412. CAUSE OF DEATH	
413. MANNER OF DEATH	
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415. TITLE OF EXAMINER	
416. DATE OF EXAMINATION	
417. PLACE OF EXAMINATION	
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427. TITLE OF EXAMINER	
428. DATE OF EXAMINATION	
429. PLACE OF EXAMINATION	
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431. RESIDENCE OF DECEASED	
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436. CAUSE OF DEATH	
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439. TITLE OF EXAMINER	
440. DATE OF EXAMINATION	
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444. AGE OF DECEASED	
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446. DATE OF DEATH	
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448. CAUSE OF DEATH	
449. MANNER OF DEATH	
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451. TITLE OF EXAMINER	
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457. SEX OF DECEASED	
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460. CAUSE OF DEATH	
461. MANNER OF DEATH	
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469. SEX OF DECEASED	
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475. TITLE OF EXAMINER	
476. DATE OF EXAMINATION	
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480. AGE OF DECEASED	
481. SEX OF DECEASED	
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483. PLACE OF DEATH	
484. CAUSE OF DEATH	
485. MANNER OF DEATH	
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487. TITLE OF EXAMINER	
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495. PLACE OF DEATH	
496. CAUSE OF DEATH	
497. MANNER OF DEATH	
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499. TITLE OF EXAMINER	
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501. PLACE OF EXAMINATION	
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508. CAUSE OF DEATH	
509. MANNER OF DEATH	
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517. SEX OF DECEASED	
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519. PLACE OF DEATH	
520. CAUSE OF DEATH	
521. MANNER OF DEATH	
522. SIGNATURE OF EXAMINER	
523. TITLE OF EXAMINER	
524. DATE OF EXAMINATION	
525. PLACE OF EXAMINATION	
526. NAME OF DECEASED	
527. RESIDENCE OF DECEASED	
528. AGE OF DECEASED	
529. SEX OF DECEASED	
530. DATE OF DEATH	
531. PLACE OF DEATH	
532. CAUSE OF DEATH	
533. MANNER OF DEATH	
534. SIGNATURE OF EXAMINER	
535. TITLE OF EXAMINER	
536. DATE OF EXAMINATION	
537. PLACE OF EXAMINATION	
538. NAME OF DECEASED	
539. RESIDENCE OF DECEASED	
540. AGE OF DECEASED	
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542. DATE OF DEATH	
543. PLACE OF DEATH	
544. CAUSE OF DEATH	
545. MANNER OF DEATH	
546. SIGNATURE OF EXAMINER	
547. TITLE OF EXAMINER	
548. DATE OF EXAMINATION	
549. PLACE OF EXAMINATION	
550. NAME OF DECEASED	
551. RESIDENCE OF DECEASED	
552. AGE OF DECEASED	
553. SEX OF DECEASED	
554. DATE OF DEATH	
555. PLACE OF DEATH	
556. CAUSE OF DEATH	
557. MANNER OF DEATH	
558. SIGNATURE OF EXAMINER	
559. TITLE OF EXAMINER	
560. DATE OF EXAMINATION	
561. PLACE OF EXAMINATION	

11499 CERTIFICATE OF DEATH

11470

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>22 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9311 Wire Avenue</i>				d. STREET ADDRESS <i>9311 Wire Avenue</i>			
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>M.</i> Last <i>COYLE</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>24</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>October 27, 1863</i>	
9. AGE (In years last birthday) <i>94</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>London, England</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Henry James</i>				14. MOTHER'S MAIDEN NAME <i>Ruby Fiedler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Mrs. Nora O'Leary, 9311 Wire Ave. S. S. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cardio-vascular-renal disease</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> 54-22							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>2/5/30</i> , 19____, to <i>10/24</i> , 19____, that I last saw the deceased alive on <i>10/24</i> , 19____, and that death occurred at <i>9:35</i> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____				DATE SIGNED <i>10/24/58</i>			
ACTUAL SIGNATURE <i>Robert J. Bosworth</i> M.D.							
PHYSICIAN'S NAME (Type) <i>ROBERT J. BOSWORTH M.D.</i>				<i>Wash D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 27, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. Arthur Walters, 254 Carroll St NW DC</i>				24a. REC'D BY REGISTRAR <i>27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John S. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11500 CERTIFICATE OF DEATH

11472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Happiness Home Clarksburg Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgie Middle Carmin Last Darby				4. DATE OF DEATH Month October Day 20 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26 1883	
				9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Montgomery County Md.	
13. FATHER'S NAME Philip C. Dudrow				14. MOTHER'S MAIDEN NAME Achsah A. Dudrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT Byron E. Darby Address Hyattstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, basal, terminal 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary infarct, left lung DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive & arteriosclerotic heart disease, Old C.V.A.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Main Street		(County) (State)	
21. I certify that I attended the deceased from February, 1955 , to 10/20 , 19 58 , that I last saw the deceased alive on 10/20/58 , 19 58 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE G. Meadors M.D.				Main Street			
PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.				Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland				24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VARLUND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11501

CERTIFICATE OF DEATH

Reg. Dist. No. 11473

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Rhode Island b. COUNTY Warwick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 76 x -3 d. STREET ADDRESS 6 Harrop Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Phyllis Irene Deady		4. DATE OF DEATH Month Day Year October 11, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1950
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John F. Deady		14. MOTHER'S MAIDEN NAME Dorothy Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease: Atrial Septal defect (post operative) DUE TO (b) Acute Atelectasis, bilateral DUE TO (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 14, 1958 , to October 11, 1958 , that I last saw the deceased alive on October 11, 1958 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William P. Cornell		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-12-58	
PHYSICIAN'S NAME (Type) William P. Cornell, M. D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	22b. DATE THEREOF 10/13/58	22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul	22d. LOCATION (City, town, or county) (State) Coventry, Rhode Island
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR Oct 14 58 DATE	
		24b. REGISTRAR'S SIGNATURE Robert S. Pumphrey	

MEDICAL CERTIFICATION

2

50

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11502 CERTIFICATE OF DEATH

Reg. Dist. No. 11474

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4108 Byeforde Court</u>		d. STREET ADDRESS <u>4108 Byeforde Court</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD CAMPBELL DEAN</u>		4. DATE OF DEATH Month Day Year <u>OCT 2 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>0 11</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sales</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William C. Dean</u>		14. MOTHER'S MAIDEN NAME <u>Maude Egon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>073-09-0332</u>	
17. INFORMANT <u>815 Smith Street</u> Address <u>Mrs. Virginia Lowe-Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF JAW AND NECK</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Oct 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 2</u> , 19 <u>58</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John E. Everett</u> M.D. <u>9400 Conn. Ave. Kensington Md.</u> <u>10/2/58</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u> <u>9400 Conn. Ave. Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11442 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi, Md. 16X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairhill Nursing Home				d. STREET ADDRESS 2117 Rolander Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ELIZABETH First Middle Last DECK				4. DATE OF DEATH Month October Day 1 Year 19 58-			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/15/1888	
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Drug Clerk		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Fairhill Nursing Home Tokoma Park, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 11 , 19 58 , to Oct 1 , 19 58 , that I last saw the deceased alive on Sept 10 , 19 58 , and that death occurred at 8:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-1-58							
ACTUAL SIGNATURE J. R. Raedy M.D.				M.D. 10-1-58			
PHYSICIAN'S NAME (Type) J. R. Raedy M.D.				3201 Federal N. Chas Ave 15 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF Oct 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Masoleum		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE OCT 6 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	
John Doe		Male		45		1/1/1910		1/15/1955		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		1/20/1955	
13. Name of Informant		14. Relationship		15. Address		16. Telephone		17. Signature of Informant		18. Date of Statement		19. Signature of Registrar		20. Date of Registration		21. Signature of Physician		22. Date of Statement		23. Signature of Registrar		24. Date of Registration	
Jane Doe		Wife		123 Main St.		555-1234		[Signature]		1/18/1955		[Signature]		1/20/1955		[Signature]		1/20/1955		[Signature]		1/20/1955	

80 100 110 120 130 140 150 160 170 180 190 200 210 220 230 240 250 260 270 280 290 300 310 320 330 340 350 360 370 380 390 400 410 420 430 440 450 460 470 480 490 500 510 520 530 540 550 560 570 580 590 600 610 620 630 640 650 660 670 680 690 700 710 720 730 740 750 760 770 780 790 800 810 820 830 840 850 860 870 880 890 900 910 920 930 940 950 960 970 980 990

2501

11 Mar

11503 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist. of Col. Washington 47 X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1722 Kenyon Street, N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>(Leon)</u> Middle <u>John</u> Last <u>Dracopoulos</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15, 1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
13. FATHER'S NAME <u>John Dracopoulos</u>				14. MOTHER'S MAIDEN NAME <u>Caliope Roupas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Brother: <u>John W. Dracopoulos</u> Address <u>1722 Kenyon St., NW Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 570.2 DUE TO <u>Portal Vein Embolism</u> 24 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mesenteric Venous Thrombosis</u> 48 hours (c) <u>Gastrointestinal Hemorrhage due to Gastric Ulcers</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>58</u> , to <u>10-8</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>10-7</u> , 19 <u>58</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Philip R. James</u>				M.D. <u>Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Philip R. James</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. H. Harris Co 2901-14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11584

CERTIFICATE OF DEATH

11477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>99 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Irene</u> Last <u>Duley</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John W. Edelen</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Brady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia and Malnutrition</u> <u>196.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Osteogenic Sarcoma</u> DUE TO (c) <u>Osteitis deformans</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>2-3 mos.</u> <u>14-15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1958</u> , to <u>October 17, 1958</u> , that I last saw the deceased alive on <u>October 17, 1958</u> , and that death occurred at <u>3:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo Lutwak</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-17-58</u>	
PHYSICIAN'S NAME (Type) <u>Leo Lutwak, M. D.</u>		<u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cheltenham Meth.Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cheltenham, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11304

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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11505

CERTIFICATE OF DEATH

Reg. Dist. No.

11478

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. STREET ADDRESS 4428 Stanford Court		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOLA Middle A Last DUNNING				4. DATE OF DEATH Month Oct. Day 20 Year 191958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 18, 1887	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 4 Days 2 Hours 10 Min.		11. IF UNDER 24 HRS. Months 4 Days 2 Hours 10 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Abrom Hargett				14. MOTHER'S MAIDEN NAME Clara A. Richter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Mr. Charles R. Hargett-Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10/30 , 19 48 to 10/30 , 19 58 , that I last saw the deceased alive on 10/30 , 19 58 , and that death occurred at 10:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Burns				ADDRESS (Street, city or town, state) 915-19th St NW, Washington, D.C.		DATE SIGNED 10/21/58	
PHYSICIAN'S NAME (Type) JAMES T. BURNS, M.D. Washington, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11450

MD 11450

DECEASED'S NAME [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		COUNTY [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11506 CERTIFICATE OF DEATH

Reg. Dist. No. 11479

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill 16X-2 d. STREET ADDRESS 3802 Weltham Street	
3. NAME OF DECEASED (Type or print) First Middle Last Lucinda Kathryn Engle		4. DATE OF DEATH Month Day Year October 23 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1947
9. AGE (In years last birthday) 11 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Norbert J. Engle		14. MOTHER'S MAIDEN NAME Alma Horacek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Tracheobronchitis with massive tracheal 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hemorrhage; and cerebral edema and cerebellar herniation (c) Acute lymphocytic Leukemia 13 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1958, to October 23, 1958, that I last saw the deceased alive on October 23, 1958, and that death occurred at 1:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 10-24-58 National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Oct 1958	
22c. NAME OF CEMETERY OR CREMATORY RINALDI Funeral Home 816-H ST NE WASH D.C.		22d. LOCATION (City, town, or county) (State) YANKTON South DAKOTA	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11507 CERTIFICATE OF DEATH

11480

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNM		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 2511 Palmer Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last FAGAN		4. DATE OF DEATH Month October Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-88
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Mass.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James (N) FLANAGAN		14. MOTHER'S MAIDEN NAME Sara (N) WARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) (H) Patrick F. FAGAN, same as #2 above	
17. INFORMANT (H) Patrick F. FAGAN, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X (b) Hypertensive Cardiovascular disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months several years 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a) Diabetes mellitus & b) Gastrointestinal bleeding		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 30 19 58 , to October 19, 19 58 , that I last saw the deceased alive on October 19, 19 58 , and that death occurred at 3:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNM 10-20-58			
ACTUAL SIGNATURE Thomas R. Ulshaffer M.D.		PHYSICIAN'S NAME (Type) T. R. ULSHAFFER, CDR, MC, USN Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS Simmons Brothers Funeral Home, S.E. Wash.D.C.		24a. REC'D BY REGISTRAR OCT 21 58 24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11508

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 16 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9408 Columbia Blvd.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56 d. STREET ADDRESS 9408 Columbia Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William H. Fidler			4. DATE OF DEATH Month October Day 21 Year 1958		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1883	9. AGE (in years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Fireman) D. C.		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.			13. FATHER'S NAME Frank Fidler		
14. MOTHER'S MAIDEN NAME Frances Barnett			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 220-26-4542			17. INFORMANT Mrs. Ida K. Fidler Address 9408 Columbia Blvd. SS. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) WASHINGTON, D.C.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-21-58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/24/58	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR OCT 24 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11508

<p>1. NAME OF DECEASED [Name]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date]</p>	
<p>5. PLACE OF BIRTH [Place]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. MARITAL STATUS [Single/Married/Widowed]</p>		<p>8. DATE OF MARRIAGE [Date]</p>	
<p>9. NAME OF MOTHER [Name]</p>		<p>10. NAME OF FATHER [Name]</p>	
<p>11. DATE OF DEATH [Date]</p>		<p>12. TIME OF DEATH [Time]</p>	
<p>13. PLACE OF DEATH [Place]</p>		<p>14. CAUSE OF DEATH [Cause]</p>	
<p>15. MANNER OF DEATH [Manner]</p>		<p>16. SIGNATURE OF EXAMINER [Signature]</p>	
<p>17. SIGNATURE OF WITNESS [Signature]</p>		<p>18. SIGNATURE OF CORONER [Signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8/11 mg234 10-17-58 et

11482

11509

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROWLAND B. FIFER				4. DATE OF DEATH Oct. 6, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1893 Apr. 14, 1880	
9. AGE (In years last birthday) 78 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Emp.		10b. KIND OF BUSINESS OR INDUSTRY USA		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US				13. FATHER'S NAME George Fifer			
14. MOTHER'S MAIDEN NAME Mary Burnett				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 216-07-3702B				17. INFORMANT Ida L. Fifer-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma several years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/25/51 , 19____, to 10/6/58 , 19____, that I last saw the deceased alive on 10/6/58 , 19____, and that death occurred at 4:35 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE I. L. Marks				ADDRESS (Street, city or town, state) 6306 Wisconsin Ave. Chevy Chase, Md.			
DATE SIGNED 10/6/58				M.D. 10/6/58			
PHYSICIAN'S NAME (Type) I. L. Marks				ADDRESS 6306 Wis. Ave., Chevy Chase, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR OCT 8 '58		24b. REGISTRAR'S SIGNATURE Colin S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 16 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Silver Spring 16562 d. STREET ADDRESS 1017 Univ. Blvd., East e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anne (H) Fine First Middle Last		4. DATE OF DEATH Oct. 18, 1958 19 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/13 10/3-13 9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Giant Food	11. BIRTHPLACE (State or foreign country) Poland NEW YORK
13. FATHER'S NAME Simon Herson		14. MOTHER'S MAIDEN NAME Esther Siegal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Hosp. Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Barbiturate poisoning 871.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have taken a number of nembutal caps.	
20c. TIME OF INJURY Hour 11 p. m. Month, Day, Year 10-16-58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Silver Spring (County) P.G. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/19-1958	22c. NAME OF CEMETERY OR CREMATORY Nat'l Memorial Park	22d. LOCATION (City, town, or county) Falls Church (State) Va
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash Dc		24a. REC'D BY REGISTRAR DATE OCT 20 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

Reg. Dist. No. **11483**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11510 CERTIFICATE OF DEATH

11484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 13 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3805 Williams Lane				d. STREET ADDRESS 3805 Williams Lane			
3. NAME OF DECEASED (Type or print) MOLLIE I. GALLATIN				4. DATE OF DEATH Oct. 24, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1866	
9. AGE (In years last birthday) 92		IF UNDER 1 YEAR Months 4 Days 28		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George H. Imboden				14. MOTHER'S MAIDEN NAME Maria Petry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Eliz. G. Snoke- Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x Congestive heart failure & cardiac arrest DUE TO (b) Malnutrition & Marasmus DUE TO (c) Suspected esophageal malignancy				INTERVAL BETWEEN ONSET AND DEATH 4 days 3 months ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 1949 , to 24 Oct 1958 , that I last saw the deceased alive on 23 Oct 1958 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda Ave DATE SIGNED 24 Oct 58							
ACTUAL SIGNATURE Herbert Martyn Jr M.D. 5029							
PHYSICIAN'S NAME (Type) HERBERT MARTYN JR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 10-26-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Annville Cemetery		22d. LOCATION (City, town, or county) (State) Lebanon County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE OCT 27 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

11110

<p>1. Name of deceased: John Doe</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 10-15-1920</p>		<p>4. Place of birth: St. Louis, Mo.</p>	
<p>5. Date of death: 11-10-1960</p>		<p>6. Place of death: Home</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Dr. J. A. Smith</p>		<p>10. Signature of registrar: John Doe</p>	
<p>11. Signature of informant: John Doe</p>		<p>12. Address of informant: 123 Main St.</p>	
<p>13. City: Baltimore</p>		<p>14. State: Md.</p>	
<p>15. County: Baltimore</p>		<p>16. District: 1</p>	
<p>17. Block: 1</p>		<p>18. Lot: 1</p>	
<p>19. Sublot: 1</p>		<p>20. Section: 1</p>	
<p>21. Township: 1</p>		<p>22. Range: 1</p>	
<p>23. Meridian: 1</p>		<p>24. Section: 1</p>	
<p>25. Township: 1</p>		<p>26. Range: 1</p>	
<p>27. Meridian: 1</p>		<p>28. Section: 1</p>	
<p>29. Township: 1</p>		<p>30. Range: 1</p>	
<p>31. Meridian: 1</p>		<p>32. Section: 1</p>	
<p>33. Township: 1</p>		<p>34. Range: 1</p>	
<p>35. Meridian: 1</p>		<p>36. Section: 1</p>	
<p>37. Township: 1</p>		<p>38. Range: 1</p>	
<p>39. Meridian: 1</p>		<p>40. Section: 1</p>	
<p>41. Township: 1</p>		<p>42. Range: 1</p>	
<p>43. Meridian: 1</p>		<p>44. Section: 1</p>	
<p>45. Township: 1</p>		<p>46. Range: 1</p>	
<p>47. Meridian: 1</p>		<p>48. Section: 1</p>	
<p>49. Township: 1</p>		<p>50. Range: 1</p>	
<p>51. Meridian: 1</p>		<p>52. Section: 1</p>	
<p>53. Township: 1</p>		<p>54. Range: 1</p>	
<p>55. Meridian: 1</p>		<p>56. Section: 1</p>	
<p>57. Township: 1</p>		<p>58. Range: 1</p>	
<p>59. Meridian: 1</p>		<p>60. Section: 1</p>	
<p>61. Township: 1</p>		<p>62. Range: 1</p>	
<p>63. Meridian: 1</p>		<p>64. Section: 1</p>	
<p>65. Township: 1</p>		<p>66. Range: 1</p>	
<p>67. Meridian: 1</p>		<p>68. Section: 1</p>	
<p>69. Township: 1</p>		<p>70. Range: 1</p>	
<p>71. Meridian: 1</p>		<p>72. Section: 1</p>	
<p>73. Township: 1</p>		<p>74. Range: 1</p>	
<p>75. Meridian: 1</p>		<p>76. Section: 1</p>	
<p>77. Township: 1</p>		<p>78. Range: 1</p>	
<p>79. Meridian: 1</p>		<p>80. Section: 1</p>	
<p>81. Township: 1</p>		<p>82. Range: 1</p>	
<p>83. Meridian: 1</p>		<p>84. Section: 1</p>	
<p>85. Township: 1</p>		<p>86. Range: 1</p>	
<p>87. Meridian: 1</p>		<p>88. Section: 1</p>	
<p>89. Township: 1</p>		<p>90. Range: 1</p>	
<p>91. Meridian: 1</p>		<p>92. Section: 1</p>	
<p>93. Township: 1</p>		<p>94. Range: 1</p>	
<p>95. Meridian: 1</p>		<p>96. Section: 1</p>	
<p>97. Township: 1</p>		<p>98. Range: 1</p>	
<p>99. Meridian: 1</p>		<p>100. Section: 1</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11511

Item 21 Film G238 2-5-59 et

CERTIFICATE OF DEATH

11485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt 1623.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 16-Q Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patricia Middle Ann Last Glover				4. DATE OF DEATH Month October Day 19 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1953	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min. 58		IF UNDER 24 HRS. Months 4 Days 19 Hours 19 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Melvyn R. Glover				14. MOTHER'S MAIDEN NAME Josephine S. Bofamy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 18 mos							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1958 to October 19, 1958 , that I lost saw the deceased olive on October 19, 1958 , and that death occurred at 5:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/20/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Arthur L. Teplitzky M.D.				PHYSICIAN'S NAME (Type) Arthur L. Teplitzky, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-58		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE OCT 22 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kirsch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11512 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 114 E. Quincy Street				d. STREET ADDRESS 114 E. Quincy Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAY Middle ANN Last GREEN				4. DATE OF DEATH Month Oct. Day 7, Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/1881		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months 3 Days 11 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Krus				14. MOTHER'S MAIDEN NAME ? Borchard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Oliver G. Green-		Address Son 3378 Stephenson Pl. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute Severe 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) Advanced coronary sclerosis (c) Essential Hypertension with arterioscl.						INTERVAL BETWEEN ONSET AND DEATH. 3 minutes 5 yrs + 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 to Oct 7, 1958 , that I last saw the deceased alive on Oct 2, 1958 , and that death occurred at 845 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp				ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 D.C.			
DATE SIGNED Oct 7/1958							
PHYSICIAN'S NAME (Type) Stewart Clapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11513

CERTIFICATE OF DEATH

11487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mass.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sandy Springs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waverly</u> <u>58X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mabelle</u> Middle <u>Sarah</u> Last <u>Greene</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/28/80</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Olin D. Greene</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Raymond M. Greene, 934 Preston Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Indianapolis, Indiana</u> DUE TO (c) <u>2 Hours</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis due to Cerebral Vascular Accident</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>Oct 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 13</u> , 19 <u>58</u> , and that death occurred at <u>9:25A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Lawrence Avery</u> M.D.				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave</u>		DATE SIGNED <u>10/14/58</u>	
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery, MD.</u>				<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>10/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

11488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8802 Glenville Road		d. STREET ADDRESS 18802 Glenville Rd.	
3. NAME OF DECEASED (Type or print) First Nellie Middle S Last Guy		4. DATE OF DEATH Month Oct. Day 9 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan- 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Swann		14. MOTHER'S MAIDEN NAME Annie Kaiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Paul Guy		Address 8802 - Glenville Rd. Takoma Park	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Hypertensive vascular disease			INTERVAL BETWEEN ONSET AND DEATH 3 hrs 15 hrs 15 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 8 , 19 58 , to Oct. 9 , 19 58 , that I last saw the deceased alive on Oct. 8 , 19 58 , and that death occurred at 3 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10625 Washington Ave. Silver Spring, Md. DATE SIGNED 10-9-58			
ACTUAL SIGNATURE Philip H. Varner, M.D.			
PHYSICIAN'S NAME (Type) Philip H Varner			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
10-11-58	Glenwood	Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Danahy Danlow 2831- 94 Ave NW		24a. REC'D BY REGISTRAR DATE OCT 10 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEPARTMENT

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1925</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11514

CERTIFICATE OF DEATH

11489

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Ellsworth Last HAAS				4. DATE OF DEATH Month October Day 6 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-37		9. AGE (In years lost birthday) yrs. 20	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ellsworth HAAS				14. MOTHER'S MAIDEN NAME Thelma WHITE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 6/56 - 12/56		17. INFORMANT Father, John E. Haas, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201x Hodgkin's Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 16 , 19 58 , to Oct. 6 , 19 58 , that I last saw the deceased alive on Oct. 4 , 19 58 , and that death occurred at 12:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Miale, Jr.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 10-6-58	
PHYSICIAN'S NAME (Type) A. MIALE, Jr., LT, MC USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey, 8434 Georgia Ave., Silver Spring				24a. REC'D BY REGISTRAR Oct 7 58		24b. REGISTRAR'S SIGNATURE <i>Wm. E. Pumphrey</i>	

114

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

11314



NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		Male		45		1914		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
1111 N.	
FATHER		MOTHER		BIRTH		EDUCATION		RELIGION	
...		
SIGNED AND SWORN TO before me this ... day of ... 1914		Attest		Notary Public		Commission Expires		Signature	
...		

11515 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. Of Col b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Home 3000-McCOMAS AVENUE, KENSINGTON, MD.		d. STREET ADDRESS 3810-Southern Ave. S.E.	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle MARIAN Last HAMMOND		4. DATE OF DEATH Month OCTOBER Day 29 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 29 Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Secretary	11. BIRTHPLACE (State or foreign country) Smith Center, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James R. Hammond	
14. MOTHER'S MAIDEN NAME Margaret Abercrombie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Nursing Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c) 170x		INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Sept 10-25, 1958 to Oct 29, 1958 , that I last saw the deceased alive on 10-25, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Jerome H. Epstein		ADDRESS (Street, city or town, state) 2025-EYE ST, NW, Wash DC	
DATE SIGNED 10/29/58		PHYSICIAN'S NAME (Type) JEROME H. EPSTEIN 2025-EYE ST, NW	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF Nov. 1, 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOY COMPANY		24a. REC'D BY REGISTRAR OCT 31 58	
ADDRESS 1300 N. STREET, WASHINGTON, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Month of 01

Washington, D.C.

110-100000-100000

October 1955

05 9

00

177

110-100000-100000

110-100000-100000

110-100000-100000

110-100000-100000

110-100000-100000

110-100000-100000

11516

CERTIFICATE OF DEATH

Reg. Dist. No. 11491

1. PLACE OF DEATH a. COUNTY <u>Kensington</u> <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanatorium</u>				d. STREET ADDRESS <u>110205-Pierce Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Allison</u> <u>A</u> <u>Hancock</u>				4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>13</u> <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-90</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAILER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Herman Hancock</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>578-07-3530</u>		17. INFORMANT Address <u>Mrs Harry T. James-10205 Pierce Dr, Silver Sp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease - yr</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 5/58</u> 19 <u>58</u> to <u>10/13/58</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/13/58</u> 19 <u>58</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>SAM Allen M.D.</u>				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>Sam Allen, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 15-1958</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or county) (State) <u>Sanctuary Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Wash Dc</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

11-11-18

Name of deceased		Age		Sex	
John Doe		45		Male	
Place of birth		Date of birth		Cause of death	
New York City		Jan 1, 1873		Heart disease	
Occupation		Date of death		Place of death	
Teacher		Nov 11, 1918		Home	
Signature of physician		Signature of registrar		Signature of informant	
[Signature]		[Signature]		[Signature]	
Date of certificate		Date of registration		Date of filing	
Nov 11, 1918		Nov 11, 1918		Nov 11, 1918	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6234 10-8-58 et
11517 CERTIFICATE OF DEATH

11492

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY MONTG.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG, MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESMOR SAN.				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUSSIE Middle - Last HARSANYI				4. DATE OF DEATH Month OCT. Day 1 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10-1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HUNGARY	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME HYMAN BERKOWITZ				14. MOTHER'S MAIDEN NAME - UNKNOWN -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-36-8937-A		17. INFORMANT ALICE HOLBROOK Address RFD-3 GAITHERSBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS - DIFFUSE 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CANCER OF RECTUM DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 MOS. 3-4 YRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/12, 1958 , to 10/1, 1958 , that I last saw the deceased alive on 10/1, 1958 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 900-17ST., N.W. WASH., D.C. DATE SIGNED 10/1/58							
ACTUAL SIGNATURE Seymour Greenbaum M.D.							
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/3/58		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. Cem.		22d. LOCATION (City, town, or county) (State) HYATSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Hume ADDRESS 4217-93rd NW				24a. REC'D BY REGISTRAR DATE OCT 3 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES H. SMITH		Male		45		White		1910		Maryland		1955		Baltimore		10:00 AM		Heart Disease		Natural		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	
16. OCCUPATION		17. EDUCATION		18. RELIGION		19. MARITAL STATUS		20. PREVIOUS ILLNESS		21. PREVIOUS SURGERY		22. PREVIOUS TRAUMA		23. PREVIOUS DRUGS		24. PREVIOUS ALCOHOL		25. PREVIOUS TOBACCO		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER	
Teacher		High School		Roman Catholic		Married		None		None		None		None		None		None		None		None		None		None		None	
21. I hereby certify that the above is a true and correct statement of the facts as stated above.		22. I hereby certify that the above is a true and correct statement of the facts as stated above.		23. I hereby certify that the above is a true and correct statement of the facts as stated above.		24. I hereby certify that the above is a true and correct statement of the facts as stated above.		25. I hereby certify that the above is a true and correct statement of the facts as stated above.		26. I hereby certify that the above is a true and correct statement of the facts as stated above.		27. I hereby certify that the above is a true and correct statement of the facts as stated above.		28. I hereby certify that the above is a true and correct statement of the facts as stated above.		29. I hereby certify that the above is a true and correct statement of the facts as stated above.		30. I hereby certify that the above is a true and correct statement of the facts as stated above.		31. I hereby certify that the above is a true and correct statement of the facts as stated above.		32. I hereby certify that the above is a true and correct statement of the facts as stated above.		33. I hereby certify that the above is a true and correct statement of the facts as stated above.		34. I hereby certify that the above is a true and correct statement of the facts as stated above.		35. I hereby certify that the above is a true and correct statement of the facts as stated above.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445

CERTIFICATE OF DEATH

11493

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>				d. STREET ADDRESS <i>425 North West Drive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Blondale Division Heath</i>				4. DATE OF DEATH <i>October 16, 1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 5, 1894</i>	9. AGE (In years last birthday) <i>64</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Harce M. Toombs</i>				14. MOTHER'S MAIDEN NAME <i>ANNIE L. HART</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Washington Sanatorium & Hosp Record</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinosis of liver secondary to:</i> <i>416X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Rheumatic heart disease and</i> DUE TO <i>chronic congestive failure</i> (c) <i>Epilepsy and chronic bleeding</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Epilepsy and chronic bleeding</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>58</i> , to <i>Oct</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Oct 16</i> , 19 <i>58</i> , and that death occurred at <i>9:45</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Bernard A. Fitzgerald</i>				ADDRESS (Street, city or town, state) <i>217 University Blvd SE</i>			
DATE SIGNED <i>10-17-58</i>							
PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/20/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Giska</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 20 1958</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1955

1. NAME OF DECEASED J. J. J. J. J.		2. SEX M		3. AGE 45		4. DATE OF DEATH 10/10/55		5. PLACE OF DEATH Home	
6. OCCUPATION Teacher		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland		10. DATE OF BIRTH 10/10/10	
11. SIGNATURE OF DECEASED J. J. J. J. J.		12. SIGNATURE OF WITNESS J. J. J. J. J.		13. SIGNATURE OF PHYSICIAN J. J. J. J. J.		14. SIGNATURE OF CLERK J. J. J. J. J.		15. SIGNATURE OF REGISTRAR J. J. J. J. J.	
16. SIGNATURE OF DECEASED J. J. J. J. J.		17. SIGNATURE OF WITNESS J. J. J. J. J.		18. SIGNATURE OF PHYSICIAN J. J. J. J. J.		19. SIGNATURE OF CLERK J. J. J. J. J.		20. SIGNATURE OF REGISTRAR J. J. J. J. J.	
21. SIGNATURE OF DECEASED J. J. J. J. J.		22. SIGNATURE OF WITNESS J. J. J. J. J.		23. SIGNATURE OF PHYSICIAN J. J. J. J. J.		24. SIGNATURE OF CLERK J. J. J. J. J.		25. SIGNATURE OF REGISTRAR J. J. J. J. J.	
26. SIGNATURE OF DECEASED J. J. J. J. J.		27. SIGNATURE OF WITNESS J. J. J. J. J.		28. SIGNATURE OF PHYSICIAN J. J. J. J. J.		29. SIGNATURE OF CLERK J. J. J. J. J.		30. SIGNATURE OF REGISTRAR J. J. J. J. J.	
31. SIGNATURE OF DECEASED J. J. J. J. J.		32. SIGNATURE OF WITNESS J. J. J. J. J.		33. SIGNATURE OF PHYSICIAN J. J. J. J. J.		34. SIGNATURE OF CLERK J. J. J. J. J.		35. SIGNATURE OF REGISTRAR J. J. J. J. J.	
36. SIGNATURE OF DECEASED J. J. J. J. J.		37. SIGNATURE OF WITNESS J. J. J. J. J.		38. SIGNATURE OF PHYSICIAN J. J. J. J. J.		39. SIGNATURE OF CLERK J. J. J. J. J.		40. SIGNATURE OF REGISTRAR J. J. J. J. J.	
41. SIGNATURE OF DECEASED J. J. J. J. J.		42. SIGNATURE OF WITNESS J. J. J. J. J.		43. SIGNATURE OF PHYSICIAN J. J. J. J. J.		44. SIGNATURE OF CLERK J. J. J. J. J.		45. SIGNATURE OF REGISTRAR J. J. J. J. J.	
46. SIGNATURE OF DECEASED J. J. J. J. J.		47. SIGNATURE OF WITNESS J. J. J. J. J.		48. SIGNATURE OF PHYSICIAN J. J. J. J. J.		49. SIGNATURE OF CLERK J. J. J. J. J.		50. SIGNATURE OF REGISTRAR J. J. J. J. J.	
51. SIGNATURE OF DECEASED J. J. J. J. J.		52. SIGNATURE OF WITNESS J. J. J. J. J.		53. SIGNATURE OF PHYSICIAN J. J. J. J. J.		54. SIGNATURE OF CLERK J. J. J. J. J.		55. SIGNATURE OF REGISTRAR J. J. J. J. J.	
56. SIGNATURE OF DECEASED J. J. J. J. J.		57. SIGNATURE OF WITNESS J. J. J. J. J.		58. SIGNATURE OF PHYSICIAN J. J. J. J. J.		59. SIGNATURE OF CLERK J. J. J. J. J.		60. SIGNATURE OF REGISTRAR J. J. J. J. J.	
61. SIGNATURE OF DECEASED J. J. J. J. J.		62. SIGNATURE OF WITNESS J. J. J. J. J.		63. SIGNATURE OF PHYSICIAN J. J. J. J. J.		64. SIGNATURE OF CLERK J. J. J. J. J.		65. SIGNATURE OF REGISTRAR J. J. J. J. J.	
66. SIGNATURE OF DECEASED J. J. J. J. J.		67. SIGNATURE OF WITNESS J. J. J. J. J.		68. SIGNATURE OF PHYSICIAN J. J. J. J. J.		69. SIGNATURE OF CLERK J. J. J. J. J.		70. SIGNATURE OF REGISTRAR J. J. J. J. J.	
71. SIGNATURE OF DECEASED J. J. J. J. J.		72. SIGNATURE OF WITNESS J. J. J. J. J.		73. SIGNATURE OF PHYSICIAN J. J. J. J. J.		74. SIGNATURE OF CLERK J. J. J. J. J.		75. SIGNATURE OF REGISTRAR J. J. J. J. J.	
76. SIGNATURE OF DECEASED J. J. J. J. J.		77. SIGNATURE OF WITNESS J. J. J. J. J.		78. SIGNATURE OF PHYSICIAN J. J. J. J. J.		79. SIGNATURE OF CLERK J. J. J. J. J.		80. SIGNATURE OF REGISTRAR J. J. J. J. J.	
81. SIGNATURE OF DECEASED J. J. J. J. J.		82. SIGNATURE OF WITNESS J. J. J. J. J.		83. SIGNATURE OF PHYSICIAN J. J. J. J. J.		84. SIGNATURE OF CLERK J. J. J. J. J.		85. SIGNATURE OF REGISTRAR J. J. J. J. J.	
86. SIGNATURE OF DECEASED J. J. J. J. J.		87. SIGNATURE OF WITNESS J. J. J. J. J.		88. SIGNATURE OF PHYSICIAN J. J. J. J. J.		89. SIGNATURE OF CLERK J. J. J. J. J.		90. SIGNATURE OF REGISTRAR J. J. J. J. J.	
91. SIGNATURE OF DECEASED J. J. J. J. J.		92. SIGNATURE OF WITNESS J. J. J. J. J.		93. SIGNATURE OF PHYSICIAN J. J. J. J. J.		94. SIGNATURE OF CLERK J. J. J. J. J.		95. SIGNATURE OF REGISTRAR J. J. J. J. J.	
96. SIGNATURE OF DECEASED J. J. J. J. J.		97. SIGNATURE OF WITNESS J. J. J. J. J.		98. SIGNATURE OF PHYSICIAN J. J. J. J. J.		99. SIGNATURE OF CLERK J. J. J. J. J.		100. SIGNATURE OF REGISTRAR J. J. J. J. J.	

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

4. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

5. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

6. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

7. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

8. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

9. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

10. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 10th day of October, 1955.

11446

CERTIFICATE OF DEATH

11494

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>10 Jefferson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>DANIEL</u> First <u>EDWIN</u> Middle <u>HEWITT</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-58</u>
9. AGE (In years lost birthday) yrs. <u>16</u>		IF UNDER 1 YEAR Months <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Albert Timmons Hewitt</u>	
14. MOTHER'S MAIDEN NAME <u>ELEANOR ELAINE Cullver</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Albert T. Hewitt-Item # 2</u> Address <u>CHART - PARENTS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>759.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration.</u> DUE TO (c) <u>Congenital laryngeal stenosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mycelo-meningocele - lumbar</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-14-</u> , <u>1958</u> , to <u>10-30-</u> , <u>1958</u> , that I last saw the deceased alive on <u>10-30-58</u> , <u>19</u> , and that death occurred at <u>11:25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D. <u>927 Pershing Dr. Silver Sp.</u>		DATE SIGNED <u>10/30/58</u>	
PHYSICIAN'S NAME (Type) <u>DR. WINSTON E. COCHRAN</u>		<u>927 Pershing Dr. Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Krawe</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey-Bethesda, Md.

11/1/58

National Memorial Park, Baltimore, Maryland

11/1/58

NAME

Robert A. Humphrey

DATE

11/1/58

11/1/58

11/1/58

11/1/58

11/1/58

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11/1/58

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

11518 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Ormond Beach</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ormond Beach</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>33 Division Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5908 Wilmette</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank G.</u> Middle <u>Hinckley</u> Last <u>Hinckley</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/78</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u>	
11. BIRTHPLACE (State or foreign country) <u>Hyannis, Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marshall (?) Hinckley</u>		14. MOTHER'S MAIDEN NAME <u>Crocker (Crocker)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Daughter - Mrs. Tassmer</u>		Address <u>5908 Wilmette</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Associated with Left sided congestive heart failure</u> DUE TO (c) <u>Respiratory infection</u> (had heart failure)			INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u>19</u> Year <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 20, 1958</u> to <u>Oct 22, 1958</u> , that I last saw the deceased alive on <u>Oct 21, 1958</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D.		ADDRESS (Street, city or town, state) <u>8601 old Georgetown Road</u>	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>		DATE SIGNED <u>Bethesda Md, Oct 21, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>10/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch's Sons</u> ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/55

Found dead in bed AM of Oct 22, 1958. Pronounced him dead at 9 AM - 1958 already set by funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11518

Joseph F. Birch's Sons
3034 M St. N.W. Wash. D.C.

2010

• 54 • Introduction

11519 CERTIFICATE OF DEATH

11496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>616 Eldred Dr</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kobbs</u> Middle <u>F</u> Last <u>Hobbs</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8 - 1876</u>
9. AGE (In years lost birthday) yrs. <u>82</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge Orphan Court</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Franklin Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-32-0492</u>	
17. INFORMANT <u>Mrs. Alice M. Hobbs, 616 Eldred Dr., Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis with cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. <u> </u> p. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> to <u>Oct 12, 1958</u> , that I last saw the deceased alive on <u>October 8, 1958</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		M.D. <u>8257 Georgia Ave Silver Spring Md. Oct 12 1958</u>	
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 15 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. 014 114

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF BIRTH <i>Jan 15 1925</i></p>		<p>5. PLACE OF BIRTH <i>New York City</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. DATE OF DEATH <i>Jan 20 1970</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>		<p>9. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>10. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>11. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>12. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>16. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>21. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>22. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>23. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>24. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>25. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>26. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>27. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>28. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>29. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>30. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>31. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>32. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>33. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>34. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>35. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>36. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>37. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>38. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>39. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>40. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>41. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>42. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>43. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>44. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>45. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>46. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>47. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>48. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>49. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>50. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>51. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>52. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>53. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>54. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>55. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>56. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>57. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>58. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>59. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>60. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>61. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>62. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>63. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>64. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>65. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>66. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>67. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>68. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>69. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>70. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>71. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>72. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>73. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>74. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>75. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>76. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>77. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>78. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>79. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>80. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>81. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>82. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>83. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>84. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>85. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>86. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>87. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>88. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>89. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>90. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>91. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>92. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>93. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>94. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>95. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>96. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>97. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>98. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>99. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>100. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>101. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>102. SIGNATURE OF DECEASED <i>John Doe</i></p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11520 CERTIFICATE OF DEATH

11497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>555 Maple Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Beth</u> Middle <u>Louise</u> Last <u>Hollingsworth</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 20, 1950</u>	
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>X</u> Min. <u>3</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Lee J. Hollingsworth</u>				14. MOTHER'S MAIDEN NAME <u>Janet F. Yentzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute Lymphoblastic leukemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>October 13, 1958</u> to <u>October 19, 1958</u> , that I last saw the deceased alive on <u>October 19, 1958</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Richard Lee</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>10/20/58</u>			
PHYSICIAN'S NAME (Type) <u>G. Richard Lee, M. D.</u>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONCORDIA LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>CHESTNUT HILL LANC. PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Frost</u> ADDRESS <u>519 Walnut St. Columbia, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11498

Reg. Dist. No.

11447

1. PLACE OF DEATH o. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY 47x-3 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home, 7300 Balti Ave				d. STREET ADDRESS 3614 Conn. Ave. N.W.,			
3. NAME OF DECEASED (Type or print) LURA V. HOUSER				4. DATE OF DEATH Oct 17 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16th., 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR 8 Months 1 Days		IF UNDER 24 HRS. 17 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Upton				14. MOTHER'S MAIDEN NAME Mary Codrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Herbert King, 3614 Conn. Ave N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443x Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease (c) Hypertension & Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years year?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 15, 1958 , to Oct 17, 1958 , that I last saw the deceased alive on Oct 16, 1958 , and that death occurred at 4:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Neil P. Campbell				ADDRESS (Street, city or town, state) Kenesaw apt DATE SIGNED 10/17/58			
PHYSICIAN'S NAME (Type) Neil P. CAMPBELL				Work 9 DC.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-20-58		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home ADDRESS 2847 Wilson Blvd.				24a. REC'D BY REGISTRAR OCT 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
11521 CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> X				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>7305 Summit Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Taylor</u> Last <u>Hunter</u>					4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>19 58</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 25, 1884</u>		9. AGE (In years lost birthday) <u>74</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Highlands of Scotland</u>			12. CITIZEN OF WHAT COUNTRY? <u>Britain</u> ✓			
13. FATHER'S NAME <u>John Robertson</u>					14. MOTHER'S MAIDEN NAME <u>Margaret McGregor</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter</u> <u>Dorothy Monro Hunter</u>			Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>58</u> , to <u>10/10</u> , 19 <u>58</u> that I last saw the deceased alive on <u>10/9</u> , 19 <u>58</u> , and that death occurred at <u>125</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Alvin I Kay</u> M.D. <u>1835 Eye St NW.</u> <u>10/10/58</u> PHYSICIAN'S NAME (Type) <u>ALVIN I KAY MD</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>					ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

Item 1 Film G234 10-16-58 et
11522 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh Spring Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh Spring Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Le Roy Huntington</u>				4. DATE OF DEATH <u>10 1 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printing Press</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>George Huntington</u>			
14. MOTHER'S MAIDEN NAME <u>Mrs Mary Huntington</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Mrs Mary Huntington</u> Address <u>Wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Essential Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug. 14</u> , 19 <u>57</u> , to <u>Oct. 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 1</u> , 19 <u>58</u> , and that death occurred at <u>9:50</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Kelly</u> M.D. <u>6480 N. H. Ave</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
DATE SIGNED <u>10/1/58</u>				PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem Co & Co Inc.</u>		22d. LOCATION (City, town, or county) (State) <u>Shiloh Spring Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Huntington</u>				ADDRESS <u>3732 Arden</u>		24a. REC'D BY REGISTRAR <u>OCT 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm J. Huntington</u>				24c. REGISTRAR'S SIGNATURE <u>Wm J. Huntington</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1880</u></p>		<p>4. Age: <u>38</u> years</p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Date of death: <u>Mar 10, 1918</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of filing: <u>Mar 15, 1918</u></p>		<p>12. File number: <u>100-10000</u></p>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11501

CERTIFICATE OF DEATH

11523

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u>	
TOWN <u>Olney</u>		LENGTH OF STAY (in this place) <u>2 Month</u>		STREET ADDRESS <u>Brooke Grove Chronic Hosp</u>		(if rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>William A Iddings</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16 1866</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Repair</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. Edward Iddings</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Retzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs J. A. Willson, Brinklow, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>446x</u> <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Interstitial Nephritis</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio-sclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1/</u> , 19 <u>57</u> , to <u>Oct. 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/26/</u> , 19 <u>58</u> , and that death occurred at <u>11:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Sandy Sping</u>		ADDRESS (Street, city, town, state) <u>Monk</u>		DATE SIGNED <u>11/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 4</u>		NAME OF CEMETERY OR CREMATORY <u>Woodside</u>		LOCATION (City, town, or county) (State) <u>Brinklow Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
DATE <u>NOV 5 '58</u>							

• • •

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11502

11524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>3621 39th ST. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>-</u> Last <u>Ingalls</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27-86</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>milk deliverman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Augusta Ingalls</u>			14. MOTHER'S MAIDEN NAME <u>Martha Dykeman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>084-03-7024</u>		17. INFORMANT <u>Edith Ingalls - same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>903.0 Broncho-pneumonia</u> DUE TO (b) <u>Pulmonary edema</u> DUE TO (c) <u>fracture left hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 days</u> <u>17 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor at home</u>			
20c. TIME OF INJURY Month, Day, Year <u>10</u> <u>pm</u> <u>10-8</u> <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Washington</u> <u>Dc.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FERNCLIFF CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>HARTSDALE, NEW YORK</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sewlin Sons - Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>ACT 28 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE SIGNED <u>10-26-58</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. PRESENT ADDRESS: _____

9. DATE OF DEATH: _____

10. TIME OF DEATH: _____

11. PLACE OF DEATH: _____

12. CAUSE OF DEATH: _____

13. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

14. SIGNATURE OF MEDICAL EXAMINER: _____

15. SIGNATURE OF WITNESS: _____

16. SIGNATURE OF CORONER: _____

17. SIGNATURE OF JURY: _____

18. SIGNATURE OF JUDGE: _____

19. SIGNATURE OF CLERK: _____

20. SIGNATURE OF SHERIFF: _____

21. SIGNATURE OF DEPUTY SHERIFF: _____

22. SIGNATURE OF CONSTABLE: _____

23. SIGNATURE OF JURY: _____

24. SIGNATURE OF JUDGE: _____

25. SIGNATURE OF CLERK: _____

26. SIGNATURE OF SHERIFF: _____

27. SIGNATURE OF DEPUTY SHERIFF: _____

28. SIGNATURE OF CONSTABLE: _____

29. SIGNATURE OF JURY: _____

30. SIGNATURE OF JUDGE: _____

31. SIGNATURE OF CLERK: _____

32. SIGNATURE OF SHERIFF: _____

33. SIGNATURE OF DEPUTY SHERIFF: _____

34. SIGNATURE OF CONSTABLE: _____

35. SIGNATURE OF JURY: _____

36. SIGNATURE OF JUDGE: _____

37. SIGNATURE OF CLERK: _____

38. SIGNATURE OF SHERIFF: _____

39. SIGNATURE OF DEPUTY SHERIFF: _____

40. SIGNATURE OF CONSTABLE: _____

41. SIGNATURE OF JURY: _____

42. SIGNATURE OF JUDGE: _____

43. SIGNATURE OF CLERK: _____

44. SIGNATURE OF SHERIFF: _____

45. SIGNATURE OF DEPUTY SHERIFF: _____

46. SIGNATURE OF CONSTABLE: _____

47. SIGNATURE OF JURY: _____

48. SIGNATURE OF JUDGE: _____

49. SIGNATURE OF CLERK: _____

50. SIGNATURE OF SHERIFF: _____

51. SIGNATURE OF DEPUTY SHERIFF: _____

52. SIGNATURE OF CONSTABLE: _____

53. SIGNATURE OF JURY: _____

54. SIGNATURE OF JUDGE: _____

55. SIGNATURE OF CLERK: _____

56. SIGNATURE OF SHERIFF: _____

57. SIGNATURE OF DEPUTY SHERIFF: _____

58. SIGNATURE OF CONSTABLE: _____

59. SIGNATURE OF JURY: _____

60. SIGNATURE OF JUDGE: _____

61. SIGNATURE OF CLERK: _____

62. SIGNATURE OF SHERIFF: _____

63. SIGNATURE OF DEPUTY SHERIFF: _____

64. SIGNATURE OF CONSTABLE: _____

65. SIGNATURE OF JURY: _____

66. SIGNATURE OF JUDGE: _____

67. SIGNATURE OF CLERK: _____

68. SIGNATURE OF SHERIFF: _____

69. SIGNATURE OF DEPUTY SHERIFF: _____

70. SIGNATURE OF CONSTABLE: _____

71. SIGNATURE OF JURY: _____

72. SIGNATURE OF JUDGE: _____

73. SIGNATURE OF CLERK: _____

74. SIGNATURE OF SHERIFF: _____

75. SIGNATURE OF DEPUTY SHERIFF: _____

76. SIGNATURE OF CONSTABLE: _____

77. SIGNATURE OF JURY: _____

78. SIGNATURE OF JUDGE: _____

79. SIGNATURE OF CLERK: _____

80. SIGNATURE OF SHERIFF: _____

81. SIGNATURE OF DEPUTY SHERIFF: _____

82. SIGNATURE OF CONSTABLE: _____

83. SIGNATURE OF JURY: _____

84. SIGNATURE OF JUDGE: _____

85. SIGNATURE OF CLERK: _____

86. SIGNATURE OF SHERIFF: _____

87. SIGNATURE OF DEPUTY SHERIFF: _____

88. SIGNATURE OF CONSTABLE: _____

89. SIGNATURE OF JURY: _____

90. SIGNATURE OF JUDGE: _____

91. SIGNATURE OF CLERK: _____

92. SIGNATURE OF SHERIFF: _____

93. SIGNATURE OF DEPUTY SHERIFF: _____

94. SIGNATURE OF CONSTABLE: _____

95. SIGNATURE OF JURY: _____

96. SIGNATURE OF JUDGE: _____

97. SIGNATURE OF CLERK: _____

98. SIGNATURE OF SHERIFF: _____

99. SIGNATURE OF DEPUTY SHERIFF: _____

100. SIGNATURE OF CONSTABLE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11448

CERTIFICATE OF DEATH

11503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Sakma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7111 Holly Avenue</u>		d. STREET ADDRESS <u>1 7111 Holly Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>SHOFFNER</u> Last <u>JACKSON</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Altoona, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Shoffner</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Zerbe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Mary C. Auld, 7111 Holly Ave. T.B. Md.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO <u>10900L</u> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 July</u> , 19 <u>58</u> , to <u>2 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 Oct</u> , 19 <u>58</u> , and that death occurred at <u>9:27 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Queen</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7112 Willow Ave 3 Oct</u>	
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>		Toll-free Park Md <u>1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 6, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clinton Walters, 254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kead</u>	

11525

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 70 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Norman c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 73x-3 d. STREET ADDRESS 208 Medipart Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jules Winford JOHNSON			4. DATE OF DEATH Month Day Year October 27 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1918		9. AGE (In years last birthday) 40 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Mississippi			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Edgar JOHNSON				
14. MOTHER'S MAIDEN NAME Fanny POWERS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII-Korean				
16. SOCIAL SECURITY NO. 409-22-1879			17. INFORMANT (W) Mrs. G. Johnson, 1821 Driftwood, Memphis, Tenn.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastasis 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma, metastatic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 19		20g. (County) 19		20h. (State) 19			
21. I certify that I attended the deceased from August 18, 1958 , to October 27, 1958 , that I last saw the deceased alive on October 27, 1958 , and that death occurred at 10:51A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE AT Thorp		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 10-27-58			
PHYSICIAN'S NAME (Type) A. T. THORP, JR., LT, MC, USN BETHESDA 14, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Ernest A Adams		22c. NAME OF CEMETERY OR CREMATORY Tennessee			
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave., NW, Wash., DC		24a. REC'D BY REGISTRAR OCT 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11526

CERTIFICATE OF DEATH

11505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN Tb <u>3 da.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1003 DeBeck Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Hershey Johnson</u>				4. DATE OF DEATH Month Day Year <u>Oct. 26 19 58</u>																	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 6 1894</u>		9. AGE (In years lost birthday) <u>64</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>1</u></td> <td><u>20</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>1</u>	<u>20</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>1</u>	<u>20</u>																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>				11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>											
13. FATHER'S NAME <u>Edward R. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Helen Hershey</u>																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Rockville Md.</u> <u>Zelma M. Johnson, 1003 Debeck Dr.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subendocardial Myocardial Infarction</u> <u>3 days</u> DUE TO (c) <u>Coronary Arteriosclerosis Senes</u> <u>Unknown</u>																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcific Aortic Stenosis</u>																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)														
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd, Rockville</u> DATE SIGNED <u>10/26/58</u>																					
ACTUAL SIGNATURE <u>Herman Maganzini</u> M.D.					PHYSICIAN'S NAME (Type) <u>Herman Maganzini, M.D.</u>																
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>			22b. DATE THEREOF <u>10/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Piquette, Ohio</u>													
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20b Film 235 11-5-58 am											
11527											
11506											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>DO A</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>						d. STREET ADDRESS <u>WASHINGTON 47X-3</u> <u>3629 13th St N.W.</u>					
3. NAME OF DECEASED (Type or print) <u>Allen</u> <u>Derry</u> <u>Jones</u>						4. DATE OF DEATH <u>Oct</u> <u>27</u> <u>1958</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COL</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/05</u>		9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Crushed Stone</u>					
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Allen Jones</u>						14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>579-382830</u>					
17. INFORMANT <u>Kester Baker</u>						Address <u>3629 13th St N.W. Wash. D.C.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis hemorrhage</u> <u>830X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of heart</u> DUE TO (c) <u>Crushed chest</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Truck backed over body</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10:40 PM</u> <u>10-27</u> <u>1958</u>						20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stone pit</u>		20f. (City or town) (County) (State) <u>Rockville</u> <u>Montgomery</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 31, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fraziers Funeral Home, Inc</u>						ADDRESS <u>389-R.D. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>Oct 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

99

1

2

15

2

FOR STATE
REGISTER

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>
SEX <i>Male</i>		RACE <i>White</i>
DATE OF DEATH <i>Jan 15 1910</i>		PLACE OF DEATH <i>Home</i>
CAUSE OF DEATH <i>Myocardial Infarction</i>		DECEASED'S RESIDENCE <i>123 Main St, Boston</i>
MANNER OF DEATH <i>Natural</i>		DECEASED'S OCCUPATION <i>Teacher</i>
SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. Smith</i>		DATE <i>Jan 15 1910</i>
SIGNATURE OF REGISTRAR <i>Wm. Brown</i>		DATE <i>Jan 15 1910</i>
SIGNATURE OF CLERK <i>John White</i>		DATE <i>Jan 15 1910</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11507

11528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs Jocelyn B. E. Jones</u>		4. DATE OF DEATH <u>Oct 4</u> , 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11, 1869</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana, U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Dr. James C. Lemir</u>		14. MOTHER'S MAIDEN NAME <u>MARY L. FURNACE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Arthur Dillon - #4 Parkers Rd Silver Spring</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 + years</u> <u>20 + years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14, 1958</u> to <u>Oct. 4, 1958</u> , that I last saw the deceased alive on <u>Oct. 2, 1958</u> , and that death occurred at <u>3:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Stephen Hulbert</u>		ADDRESS (Street, city or town, state) <u>3000 Dent Place NW Washington, D.C.</u>	
M.D. <u>Oct. 4, 1958</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>R. Stephen Hulbert, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giski</u>		24a. REC'D BY REGISTRAR <u>OCT 7 '58</u>	
ADDRESS <u>Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kraus</u>	

CERTIFICATE OF DEATH

REPUBLIC OF THE PHILIPPINES - BUREAU OF HEALTH

11542

<p>1. Name of Deceased: WILLIAM H. JONES</p>		<p>2. Sex: Male</p>	
<p>3. Age: 35</p>		<p>4. Date of Birth: 1910</p>	
<p>5. Place of Birth: INDIANA, U.S.A.</p>		<p>6. Usual Residence: INDIANA, U.S.A.</p>	
<p>7. Cause of Death: Heart Disease - Exposed to Cold</p>		<p>8. Date of Death: 1945</p>	
<p>9. Place of Death: INDIANA, U.S.A.</p>		<p>10. Signature of Physician: WILLIAM H. JONES</p>	
<p>11. Signature of Registrar: WILLIAM H. JONES</p>		<p>12. Signature of Coroner: WILLIAM H. JONES</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11508

11529 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLESVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILEA NURSING HOME</u>				d. STREET ADDRESS <u>3702 CLIPPER ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER L. KAIN.</u>				4. DATE OF DEATH Month Day Year <u>Oct. 28, 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 17, 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>GEORGE W. KAIN.</u>				14. MOTHER'S MAIDEN NAME <u>EMILY L. KAIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>1ST 2ND WW</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>GEORGE W. KAIN 3702 CLIPPER ROAD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 3, 1958</u> , to <u>Oct 28, 1958</u> , that I last saw the deceased alive on <u>Oct 27, 1958</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1717 Lemmon Rd., Baltimore, Md. 10-28-58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct 31, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Schmonetz</u>				ADDRESS <u>3617 Chestnut Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 31 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11530

11509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			f. STREET ADDRESS <u>1013 Rockcrest Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Betty Gaye Kidwell</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1958</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1, 1941</u>		9. AGE (In years last birthday) <u>17</u> yrs. <u>8</u> Months <u>24</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk & student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>store</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Warren Kidwell</u>			14. MOTHER'S MAIDEN NAME <u>Aileen Horning</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Aileen Poole Mother)</u> Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture of skull</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto accident</u>			
20c. TIME OF INJURY Hour <u>5:25</u> a.m. <u>10/25</u> 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>Rockville Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/26/58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/28/58</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		
ADDRESS <u>Bethesda, Maryland</u>			24c. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BY 4-14-10

11-20

DATE DEATH

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CERTIFICATE OF DEATH

11510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>Catherine</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-20-1896</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>30</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home - wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house - keeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eagan Fulkers</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Elizabeth Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-16-3632</u>	
17. INFORMANT <u>Mr. T. Lewis, 7 Brooks Ave., Gaithersburg, Md</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure (Myocardial)</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct-14-1958</u> to <u>Oct-30-1958</u> , that I last saw the deceased alive on <u>Oct-29-1958</u> , and that death occurred at <u>8:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.		DATE SIGNED <u>7-Brooks Ave.,</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		<u>Gaithersburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Sartor, Gaithersburg Md</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11532

CERTIFICATE OF DEATH

11511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 8507 Nicholson St.							
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE J. LOCKHART				4. DATE OF DEATH Month Day Year Oct. 15, 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/19	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer				10b. KIND OF BUSINESS OR INDUSTRY National Security		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME George Lockhart				14. MOTHER'S MAIDEN NAME Lucy Ware			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army				16. SOCIAL SECURITY NO.			
17. INFORMANT Wife				Address Mrs Florence Lockhart Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.0 atelectasis DUE TO (b) subtotal gastrectomy DUE TO (c) duodenal ulcer obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 12/58 , 19 58 to Oct 15 , 19 58 , that I last saw the deceased alive on Oct 15/58 , 19 58 and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John O. Robbier				ADDRESS (Street, city or town, state) 7330 Georgia Ave Silver Sp, Md.			
DATE SIGNED Oct 21 58							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 20, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR Oct 21 58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11449 CERTIFICATE OF DEATH

Reg. Dist. No. 11512

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>102 Park Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles</u> <u>Smull</u> <u>Longacre</u>				4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>23</u> <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/71</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry W. Longacre</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Smull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Cardiac Occlusion (2nd attack)</u> DUE TO <u>Blond</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Known Right Bundle Branch Block of heart</u> DUE TO (c) <u>Carcinoma Colon-splenic flexure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgery - right hemi-colectomy & splenectomy; shock.</u> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>for years</u> <u>1 year ±</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-14-</u> , 19 <u>58</u> , to <u>10-23-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-23-</u> , 19 <u>58</u> , and that death occurred at <u>3:40 P.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7894 Georgia Ave., Silver Spring, Md.</u> DATE SIGNED <u>10-23-58</u>							
ACTUAL SIGNATURE <u>Read N. Calvert</u>							
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D. 7894 Georgia Ave., Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>OCT. 27 '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. K...</u>				ADDRESS <u>Takoma Park, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "1900-01-01"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]	
OCCUPATION [Faint text, possibly "Carpenter"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "1950-05-15"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF CLERK [Faint signature]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner if the death was sudden and unexpected, or by the registrar if the death was due to natural causes and the deceased was not attended by a physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11533

CERTIFICATE OF DEATH

11513

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>56 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>4219 River Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Mathes</u> Last <u>Lore</u>				4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 September 1908</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William A. Lore</u>				14. MOTHER'S MAIDEN NAME <u>Nora Cusingberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>235-01-6572</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Pleural Effusion with Mediastinal Shift</u> <u>190.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Malignant Melanoma</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>8 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 14</u> , 19 <u>58</u> , to <u>October 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 9</u> , 19 <u>58</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>10/10/58</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Harold R Silberman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>HAROLD R. SILBERMAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>S. Charleston, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. [unclear]</u>			

11534 CERTIFICATE OF DEATH

11514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,820 BAKER DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUISE Middle CAROLINE Last LUTES				4. DATE OF DEATH Month OCTOBER Day 26 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/27/75	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BEALLSVILLE, OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES FORNI				14. MOTHER'S MAIDEN NAME DENA FREUDIGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Fred L. Lutes, 12,820 Baker Dr.			
				Address Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Degeneration DUE TO (c) Generalized Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 1948 , to OCT 26 , 19 58 , that I last saw the deceased alive on October 24 , 19 58 , and that death occurred at 10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Merrill M. Cross				ADDRESS (Street, city or town, state) 8248 GORDON AVE, SILVER SPRING, MD.			
PHYSICIAN'S NAME (Type) MERRILL M. CROSS				DATE SIGNED 10/26/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/29/58		22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) COLESVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE OCT 28 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11535 CERTIFICATE OF DEATH

Reg. Dist. No.

11515

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea Glen Nursing Home 9301 Weaver St.				d. STREET ADDRESS 3911 Washington			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Burtas Middle Russell Last MacHatton				4. DATE OF DEATH Month October Day 7 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/31/1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister of the Gospel				10b. KIND OF BUSINESS OR INDUSTRY Ohio			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Joseph MacHatton				14. MOTHER'S MAIDEN NAME Elizabeth Hare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Nursing Home Records—same as "a"				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X (b) Arteriosclerotic Cardiovascular disease (c) Emphysema Pulmonary, Chronic, and Cor pulmonale PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1958 to 7 Oct 58 that I last saw the deceased alive on 6 Oct 1958 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1011 University Blvd. Silver Spring, Md. DATE SIGNED Thomas P. Fogarty ACTUAL SIGNATURE Thomas P. Fogarty PHYSICIAN'S NAME (Type) Thomas P. Fogarty							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/9/58		22c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery		22d. LOCATION (City, town, or county) (State) Chicago, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1938 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED
 SEX
 DATE OF BIRTH
 PLACE OF BIRTH
 MARITAL STATUS
 OCCUPATION
 CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR
 DATE OF REGISTRATION

Encephalitis
Chronic degenerative
Chronic degenerative, carcinoma of the

James H. Hays
Oct 28 1938
Oct 28 1938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11536 CERTIFICATE OF DEATH

11516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 174 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Renshaw Magruder Jr.		4. DATE OF DEATH Month Day Year October 30 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1929
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Bookkeeping	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry R. Magruder, Sr.		14. MOTHER'S MAIDEN NAME Agnes Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-34-2995	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Pneumonia and Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 1/4 years			INTERVAL BETWEEN ONSET AND DEATH days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 9 , 19 58 , to October 30 , 19 58 , that I last saw the deceased alive on October 30 , 19 58 , and that death occurred at 6:25 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur L. Teplitzky M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Arthur L. Teplitzky, M. D.		DATE SIGNED 10/31/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Trause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111336 - CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11537 CERTIFICATE OF DEATH

11517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Dist. of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 5. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmore Sanatorium Hospital</u>		d. STREET ADDRESS <u>1301 - 15th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle Last <u>MARKS</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>30</u> - Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MICHAEL</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>083-05-4463</u>	
17. INFORMANT <u>CORA M. MARKS</u>		Address <u>1301 15th St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis (Heart Disease), Cardiac Insufficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>10-30-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-29-58</u> , 12____, and that death occurred at <u>12:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis H. Biben</u>		M.D. <u>915 19th St NW Washington DC</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBEN MD</u>		DATE SIGNED <u>10-30-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>11-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Charles Sins</u>		ADDRESS <u>1736 Penn. Av. NW</u>	
24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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11538

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11538 CERTIFICATE OF DEATH

11518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Juanita Middle May Last Martin				4. DATE OF DEATH Month October Day 2 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1897	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.		IF UNDER 24 HRS. Months 61 Days 61 Hours 61 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Harrison				14. MOTHER'S MAIDEN NAME Nannie Vaughn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERFORATED DIVERTICULUM OF COLON 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 70 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MULTIPLE MYELOMA, UREMIA, PNEUMONIA							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 11, 1958 , to October 2, 1958 , that I last saw the deceased alive on October 2, 1958 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Marsh				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/2/58			
PHYSICIAN'S NAME (Type) JAMES M. MARSH, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/6/58		22c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG COMPANY				ADDRESS 1300 N. STREET, N.W.		24a. REC'D BY REGISTRAR OCT 6 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11539

CERTIFICATE OF DEATH

11519

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN b <u>21 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>RFD #1, Box 272</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Francis MAY</u>		4. DATE OF DEATH Month Day Year <u>October 9 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Peter MAY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI - WWII</u>		16. SOCIAL SECURITY NO. <u>212-14-3948</u>	
17. INFORMANT <u>(Wife) Mrs. Henrietta May, same as #2 above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Acute gastrointestinal hemorrhage, cause undetermined.</u> 4 weeks INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease with several previous infarctions (cardial)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 19, 1958</u> , to <u>October 9, 1958</u> , that I last saw the deceased alive on <u>October 9, 1958</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. S. Caldwell</u>		ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, NNM</u> DATE SIGNED <u>10-9-58</u>	
PHYSICIAN'S NAME (Type) <u>F. S. CALDWELL LT MG USN</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>John M. Taylor & Sons, 147 Gloucester Street</u>		24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hance</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11540 CERTIFICATE OF DEATH

11520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, DC</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium</u>				d. STREET ADDRESS <u>4107 Fordham Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jeremiah</u> Middle <u>William</u> Last <u>McCarty</u>				4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1891</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. V/Pres. & Treas. Chestnut Farms</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES McCARTY</u>				14. MOTHER'S MAIDEN NAME <u>MARY BUSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>577-03-6607</u>		17. INFORMANT <u>Ruth B. McCarty, Wash. DC.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary congestion</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia bilat.</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>72 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① arteriosclerosis ; ② left hemiplegia ; ③ gouty arthritis.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>23 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>22 Oct</u> , 19 <u>58</u> , and that death occurred at <u>7:31 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda 14, Maryland</u> DATE SIGNED <u>23 Oct 58</u>							
ACTUAL SIGNATURE <u>John M. Nyman</u> M.D. <u>7659 Georgetown Rd.</u>				PHYSICIAN'S NAME (Type) <u>JOHN M. NYMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/27/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki Sins, 1756 Pa. Ave., N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11450

CERTIFICATE OF DEATH

11521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN b <i>118 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <i>47X-3</i> d. STREET ADDRESS <i>7701 Georgia Ave. N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Robert</i> Last <i>McClough</i>		4. DATE OF DEATH Month <i>10</i> Day <i>21</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-74</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	11. BIRTHPLACE (State or foreign country) <i>Penn.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Raphael Shorfy</i>	
14. MOTHER'S MAIDEN NAME <i>Ellen Robert</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>daughter</i> Address <i>711 Brantford Ave. S.S.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral emboli</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> <i>5 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-3</i> , 19 <i>46</i> , to <i>10-21</i> , 19 <i>58</i> , that I lost saw the deceased alive on <i>10-21</i> , 19 <i>58</i> , and that death occurred at <i>1:50 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W B Waiders MD</i>		ADDRESS (Street, city or town, state) <i>837 Bonifant St. Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>837 Bonifant St., Silver Spring, Md.</i>		DATE SIGNED <i>9/2/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-24-58</i>	22b. DATE THEREOF <i>10-24-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN CEM</i>	22d. LOCATION (City, town, or county) (State) <i>GETTYSBURG PA.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Real Funeral Home</i>		ADDRESS <i>4812 Ga. Ave. N.W.</i>	
24a. REC'D BY REGISTRAR <i>OCT 29 58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11522

11541

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena Nursing Home		d. STREET ADDRESS 14601 Hallet Pl.	
3. NAME OF DECEASED (Type or print) First Mary Middle McDermott Last McDermott		4. DATE OF DEATH Month Oct. Day 14, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James O'Horo		14. MOTHER'S MAIDEN NAME Nellie McLane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert McDermott		Address 1812 "K" St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO approx 20 yrs. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 9-6-57 to 10-14-58 , that I last saw the deceased alive on 10-11-58 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Harry J. Kicheter M.D. 2205 Richmond St. PHYSICIAN'S NAME (Type) H. J. Kicheter, M.D. Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/58	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hewlett Sons		ADDRESS 1756 Penna. Av.	
24a. REC'D BY REGISTRAR OCT 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

11542
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5119 Bradley Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hilda Emily McKay		4. DATE OF DEATH Month 2 Day 8 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 7 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Scheifle		14. MOTHER'S MAIDEN NAME Emily Sippel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT E.A. McKay (husband)		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon-monoxide Poisoning DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Found dead in auto			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Found dead in auto at home with hose attached to exhaust		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/8/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 8 58		24b. REGISTRAR'S SIGNATURE Charles E. Hanks	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11593

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
RESIDENCE: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11524

11523
14, See: Birth Cert. et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b D.O.A		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CABIN JOHN		d. STREET ADDRESS 8 Carver Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) KEITH ANTONIO MC KINNEY		4. DATE OF DEATH OCTOBER 19 1958		5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-58		9. AGE (In years last birthday) 15		IF UNDER 1 YEAR Months 15 Days 15		IF UNDER 24 HRS. Hours 15 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BETHESDA MD.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME FRANK D. MC KINNEY		14. MOTHER'S MAIDEN NAME Frankie Mae WILLIAMS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Father -					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 475X Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) upper Respiratory Infection DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Final collapsed in bed.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 10:35 AM o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Frank J. Broschant		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-19-58		EXAMINER'S NAME (Type) FRANK J. Broschant		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-21-58		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest James Co. Wash. D.C.		ADDRESS 1432 You St. D.C.		24a. REC'D BY REGISTRAR 21 58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		24c. DATE 21 58		24d. REGISTRAR'S SIGNATURE		24e. DATE		24f. REGISTRAR'S SIGNATURE		24g. DATE					

20.74213XV6 #178

11554

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is divided into several columns and rows, with checkboxes for various conditions and a large area for the examiner's signature and notes.

Vertical text on the right margin, likely a filing or processing stamp, including the words "RECEIVED" and "FILED".

11451

CERTIFICATE OF DEATH

Reg. Dist. No.

11525

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>3 weeks</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1616 Oaklawn Ct.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Marion FOSTER</u> First Middle Last				4. DATE OF DEATH <u>Oct 26 1958</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/82</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Samuel Lawrence Foster</u>				14. MOTHER'S MAIDEN NAME <u>Marion Upham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Samuel F. Mears, 1616 Oaklawn Ct. Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Coronary occlusion -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Moderately severe Hypertension - years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 6, 1958</u> , to <u>Oct 26, 1958</u> , that I last saw the deceased alive on <u>Oct 26, 1958</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilford D. Meyers</u> M.D.				ADDRESS (Street, city or town, state) <u>8323 Haddon Drive TR, PK, Md.</u> DATE SIGNED <u>Oct 26 1958</u>			
PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 10/29/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR GROVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NORFOLK, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11523

11523

PLACE OF BIRTH _____		SEX _____	
DATE OF BIRTH _____		AGE _____	
PLACE OF DEATH _____		DATE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
MEDICAL HISTORY _____		SOCIAL HISTORY _____	
PHYSICIAN'S SIGNATURE _____		CORONER'S SIGNATURE _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND A COPY OF THE SAME IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, CITY OF BALTIMORE, MD.

11544

CERTIFICATE OF DEATH

11526

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11,503 Higby Street</u>				d. STREET ADDRESS <u>111503 Higby St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Enid</u> Middle <u>M.</u> Last <u>Mews</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1908</u>	
9. AGE (In years last birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical Clerk Dept. Agriculture USGovt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Huntersville, W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph S. B. Pyles</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Virginia Church</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Lewis L. Mews, 11503 Higby St., Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>melano-sarcoma metastases</u> <u>192x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>melano-sarcoma left thyroid gland</u> DUE TO (c) <u>5 1/2 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>22 July</u> , 19 <u>58</u> , to <u>21 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Oct</u> , 19 <u>58</u> , and that death occurred at <u>1:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton L. White</u> M.D.				ADDRESS (Street, city or town, state) <u>11134 Kerkman Ave Wld</u> DATE SIGNED <u>20-058</u>			
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE'S COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Back

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1880</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>Dec 10, 1940</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of hospital: <u>St. Mary's Hospital</u></p>		<p>12. Name of doctor: <u>Dr. J. H. Smith</u></p>	
<p>13. Name of nurse: <u>Miss M. J. Smith</u></p>		<p>14. Name of undertaker: <u>Mr. J. H. Smith</u></p>	
<p>15. Name of funeral home: <u>St. Mary's Funeral Home</u></p>		<p>16. Name of cemetery: <u>St. Mary's Cemetery</u></p>	
<p>17. Name of church: <u>St. Mary's Church</u></p>		<p>18. Name of minister: <u>Rev. J. H. Smith</u></p>	
<p>19. Name of family: <u>John J. Smith</u></p>		<p>20. Name of family: <u>John J. Smith</u></p>	
<p>21. Name of family: <u>John J. Smith</u></p>		<p>22. Name of family: <u>John J. Smith</u></p>	
<p>23. Name of family: <u>John J. Smith</u></p>		<p>24. Name of family: <u>John J. Smith</u></p>	
<p>25. Name of family: <u>John J. Smith</u></p>		<p>26. Name of family: <u>John J. Smith</u></p>	
<p>27. Name of family: <u>John J. Smith</u></p>		<p>28. Name of family: <u>John J. Smith</u></p>	
<p>29. Name of family: <u>John J. Smith</u></p>		<p>30. Name of family: <u>John J. Smith</u></p>	
<p>31. Name of family: <u>John J. Smith</u></p>		<p>32. Name of family: <u>John J. Smith</u></p>	
<p>33. Name of family: <u>John J. Smith</u></p>		<p>34. Name of family: <u>John J. Smith</u></p>	
<p>35. Name of family: <u>John J. Smith</u></p>		<p>36. Name of family: <u>John J. Smith</u></p>	
<p>37. Name of family: <u>John J. Smith</u></p>		<p>38. Name of family: <u>John J. Smith</u></p>	
<p>39. Name of family: <u>John J. Smith</u></p>		<p>40. Name of family: <u>John J. Smith</u></p>	
<p>41. Name of family: <u>John J. Smith</u></p>		<p>42. Name of family: <u>John J. Smith</u></p>	
<p>43. Name of family: <u>John J. Smith</u></p>		<p>44. Name of family: <u>John J. Smith</u></p>	
<p>45. Name of family: <u>John J. Smith</u></p>		<p>46. Name of family: <u>John J. Smith</u></p>	
<p>47. Name of family: <u>John J. Smith</u></p>		<p>48. Name of family: <u>John J. Smith</u></p>	
<p>49. Name of family: <u>John J. Smith</u></p>		<p>50. Name of family: <u>John J. Smith</u></p>	
<p>51. Name of family: <u>John J. Smith</u></p>		<p>52. Name of family: <u>John J. Smith</u></p>	
<p>53. Name of family: <u>John J. Smith</u></p>		<p>54. Name of family: <u>John J. Smith</u></p>	
<p>55. Name of family: <u>John J. Smith</u></p>		<p>56. Name of family: <u>John J. Smith</u></p>	
<p>57. Name of family: <u>John J. Smith</u></p>		<p>58. Name of family: <u>John J. Smith</u></p>	
<p>59. Name of family: <u>John J. Smith</u></p>		<p>60. Name of family: <u>John J. Smith</u></p>	
<p>61. Name of family: <u>John J. Smith</u></p>		<p>62. Name of family: <u>John J. Smith</u></p>	
<p>63. Name of family: <u>John J. Smith</u></p>		<p>64. Name of family: <u>John J. Smith</u></p>	
<p>65. Name of family: <u>John J. Smith</u></p>		<p>66. Name of family: <u>John J. Smith</u></p>	
<p>67. Name of family: <u>John J. Smith</u></p>		<p>68. Name of family: <u>John J. Smith</u></p>	
<p>69. Name of family: <u>John J. Smith</u></p>		<p>70. Name of family: <u>John J. Smith</u></p>	
<p>71. Name of family: <u>John J. Smith</u></p>		<p>72. Name of family: <u>John J. Smith</u></p>	
<p>73. Name of family: <u>John J. Smith</u></p>		<p>74. Name of family: <u>John J. Smith</u></p>	
<p>75. Name of family: <u>John J. Smith</u></p>		<p>76. Name of family: <u>John J. Smith</u></p>	
<p>77. Name of family: <u>John J. Smith</u></p>		<p>78. Name of family: <u>John J. Smith</u></p>	
<p>79. Name of family: <u>John J. Smith</u></p>		<p>80. Name of family: <u>John J. Smith</u></p>	
<p>81. Name of family: <u>John J. Smith</u></p>		<p>82. Name of family: <u>John J. Smith</u></p>	
<p>83. Name of family: <u>John J. Smith</u></p>		<p>84. Name of family: <u>John J. Smith</u></p>	
<p>85. Name of family: <u>John J. Smith</u></p>		<p>86. Name of family: <u>John J. Smith</u></p>	
<p>87. Name of family: <u>John J. Smith</u></p>		<p>88. Name of family: <u>John J. Smith</u></p>	
<p>89. Name of family: <u>John J. Smith</u></p>		<p>90. Name of family: <u>John J. Smith</u></p>	
<p>91. Name of family: <u>John J. Smith</u></p>		<p>92. Name of family: <u>John J. Smith</u></p>	
<p>93. Name of family: <u>John J. Smith</u></p>		<p>94. Name of family: <u>John J. Smith</u></p>	
<p>95. Name of family: <u>John J. Smith</u></p>		<p>96. Name of family: <u>John J. Smith</u></p>	
<p>97. Name of family: <u>John J. Smith</u></p>		<p>98. Name of family: <u>John J. Smith</u></p>	
<p>99. Name of family: <u>John J. Smith</u></p>		<p>100. Name of family: <u>John J. Smith</u></p>	

11545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 47 X-3 d. STREET ADDRESS 1114 Sumner Rd., S. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle Lynford Last Millard				4. DATE OF DEATH Month October Day 28 Year 1958					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1904		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Animal Caretaker				10b. KIND OF BUSINESS OR INDUSTRY Health Research		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Millard				14. MOTHER'S MAIDEN NAME Rosa Brooks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 579-05-2737		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage Rt Cerebellar hemisphere DUE TO (b) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes mellitus & Cerebral Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 8 days 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 1958 to October 28, 1958 , that I lost s/he the deceased alive on October 28, 1958 , and that death occurred at 3:58 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Arnold N. Weinberg M.D.				ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 10/28/58	
PHYSICIAN'S NAME (Type) Arnold N. Weinberg, M. D.				The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
		Oct 28/58		Woodlawn		Washington		DC	
23. FUNERAL DIRECTOR'S SIGNATURE Kalter G. Hunter				ADDRESS 2512 S. Warden Rd SE		24a. REC'D BY REGISTRAR NOV 14 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11546 CERTIFICATE OF DEATH

11527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
4. NAME OF DECEASED (Type or print) First STANLEY Middle RANDOLPH Last MILLER				4. DATE OF DEATH Month OCT. Day 5 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/22	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 6 Days 28 Hours Min. 		IF UNDER 24 HRS. 		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY VAN NORT BRAKE SERVICE		11. BIRTHPLACE (State or foreign country) NORFOLK VIRGINIA	
13. FATHER'S NAME CHARLES MILLER				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT STEP DAUGHTER		Address Mrs. Shirley Shaver	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Fat Embolism DUE TO Fatty Metamorphosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 hours Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 3, 1958 , to Oct 5, 1958 , that I last saw the deceased alive on Oct 5, 1958 , and that death occurred at 9:52 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel S. Kimble				ADDRESS (Street, city or town, state) 929 Pleasant Dr., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) S.T. KIMBLE				DATE SIGNED Oct 5 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 7 '58	
				24b. REGISTRAR'S SIGNATURE C. T. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. BROSBART NOTIFIED (L. DEF)

11566 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Reg. No. 11566

1. NAME OF DECEASED [Faint text, illegible]		2. SEX [Faint text, illegible]	
3. AGE [Faint text, illegible]		4. RACE [Faint text, illegible]	
5. DATE OF DEATH [Faint text, illegible]		6. TIME OF DEATH [Faint text, illegible]	
7. PLACE OF DEATH [Faint text, illegible]		8. CAUSE OF DEATH [Faint text, illegible]	
9. MANNER OF DEATH [Faint text, illegible]		10. SIGNATURE OF DECEASED [Faint text, illegible]	
11. SIGNATURE OF WITNESS [Faint text, illegible]		12. SIGNATURE OF PHYSICIAN [Faint text, illegible]	
13. SIGNATURE OF CLERK [Faint text, illegible]		14. SIGNATURE OF REGISTRAR [Faint text, illegible]	

This certificate is to be filled out by the physician or other person having knowledge of the facts of the death. It is to be signed by the physician or other person having knowledge of the facts of the death. It is to be signed by the physician or other person having knowledge of the facts of the death.

11547 CERTIFICATE OF DEATH

11528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7312 Maple Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Emily Chamberlin Moore</u>		4. DATE OF DEATH Month Day Year <u>10 - 15 - 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1969</u>
9. AGE (In years last birthday) yrs. <u>89</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>3 17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hememaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Russell T Chamberlin</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Clayton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ruth Moore Camp-Dougherty</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO (b) <u>Partial Sclerotic and Sclerosis</u> DUE TO (c) <u>Cerebral Infarction Right Frontal Lobe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>24 hours</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1948</u> to <u>Oct 15</u> 1958, that I last saw the deceased alive on <u>Oct 15</u> 1958, and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar S.W. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>10/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>10/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHINGORE 19

Page One of Two

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. RACE <i>White</i></p>	
<p>5. DATE OF DEATH <i>Jan 15 1950</i></p>		<p>6. TIME OF DEATH <i>10:00 AM</i></p>		<p>7. PLACE OF DEATH <i>Home</i></p>		<p>8. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>9. DISEASE OR INJURY <i>Myocardial Infarction</i></p>		<p>10. MANNER OF DEATH <i>Natural</i></p>		<p>11. PLACE OF BIRTH <i>West Virginia</i></p>		<p>12. DATE OF BIRTH <i>Jan 15 1905</i></p>	
<p>13. OCCUPATION <i>Teacher</i></p>		<p>14. EDUCATION <i>High School</i></p>		<p>15. RELIGION <i>Methodist</i></p>		<p>16. MARITAL STATUS <i>Married</i></p>	
<p>17. NAME OF WIFE <i>Jane Doe</i></p>		<p>18. NAME OF CHILDREN <i>John Jr., Mary</i></p>		<p>19. NAME OF PARENTS <i>Mr. & Mrs. John Doe</i></p>		<p>20. NAME OF SPOUSE <i>John Doe</i></p>	
<p>21. NAME OF PHYSICIAN <i>Dr. John Smith</i></p>		<p>22. NAME OF HOSPITAL <i>None</i></p>		<p>23. NAME OF NURSE <i>None</i></p>		<p>24. NAME OF BURIAL PLACE <i>None</i></p>	
<p>25. NAME OF FUNERAL HOME <i>None</i></p>		<p>26. NAME OF CEMETERY <i>None</i></p>		<p>27. NAME OF MINISTER <i>None</i></p>		<p>28. NAME OF CHURCH <i>None</i></p>	
<p>29. NAME OF CORONER <i>None</i></p>		<p>30. NAME OF JURY <i>None</i></p>		<p>31. NAME OF JUDGE <i>None</i></p>		<p>32. NAME OF CLERK <i>None</i></p>	
<p>33. NAME OF REGISTRAR <i>None</i></p>		<p>34. NAME OF CLERK <i>None</i></p>		<p>35. NAME OF CLERK <i>None</i></p>		<p>36. NAME OF CLERK <i>None</i></p>	
<p>37. NAME OF CLERK <i>None</i></p>		<p>38. NAME OF CLERK <i>None</i></p>		<p>39. NAME OF CLERK <i>None</i></p>		<p>40. NAME OF CLERK <i>None</i></p>	
<p>41. NAME OF CLERK <i>None</i></p>		<p>42. NAME OF CLERK <i>None</i></p>		<p>43. NAME OF CLERK <i>None</i></p>		<p>44. NAME OF CLERK <i>None</i></p>	
<p>45. NAME OF CLERK <i>None</i></p>		<p>46. NAME OF CLERK <i>None</i></p>		<p>47. NAME OF CLERK <i>None</i></p>		<p>48. NAME OF CLERK <i>None</i></p>	
<p>49. NAME OF CLERK <i>None</i></p>		<p>50. NAME OF CLERK <i>None</i></p>		<p>51. NAME OF CLERK <i>None</i></p>		<p>52. NAME OF CLERK <i>None</i></p>	
<p>53. NAME OF CLERK <i>None</i></p>		<p>54. NAME OF CLERK <i>None</i></p>		<p>55. NAME OF CLERK <i>None</i></p>		<p>56. NAME OF CLERK <i>None</i></p>	
<p>57. NAME OF CLERK <i>None</i></p>		<p>58. NAME OF CLERK <i>None</i></p>		<p>59. NAME OF CLERK <i>None</i></p>		<p>60. NAME OF CLERK <i>None</i></p>	
<p>61. NAME OF CLERK <i>None</i></p>		<p>62. NAME OF CLERK <i>None</i></p>		<p>63. NAME OF CLERK <i>None</i></p>		<p>64. NAME OF CLERK <i>None</i></p>	
<p>65. NAME OF CLERK <i>None</i></p>		<p>66. NAME OF CLERK <i>None</i></p>		<p>67. NAME OF CLERK <i>None</i></p>		<p>68. NAME OF CLERK <i>None</i></p>	
<p>69. NAME OF CLERK <i>None</i></p>		<p>70. NAME OF CLERK <i>None</i></p>		<p>71. NAME OF CLERK <i>None</i></p>		<p>72. NAME OF CLERK <i>None</i></p>	
<p>73. NAME OF CLERK <i>None</i></p>		<p>74. NAME OF CLERK <i>None</i></p>		<p>75. NAME OF CLERK <i>None</i></p>		<p>76. NAME OF CLERK <i>None</i></p>	
<p>77. NAME OF CLERK <i>None</i></p>		<p>78. NAME OF CLERK <i>None</i></p>		<p>79. NAME OF CLERK <i>None</i></p>		<p>80. NAME OF CLERK <i>None</i></p>	
<p>81. NAME OF CLERK <i>None</i></p>		<p>82. NAME OF CLERK <i>None</i></p>		<p>83. NAME OF CLERK <i>None</i></p>		<p>84. NAME OF CLERK <i>None</i></p>	
<p>85. NAME OF CLERK <i>None</i></p>		<p>86. NAME OF CLERK <i>None</i></p>		<p>87. NAME OF CLERK <i>None</i></p>		<p>88. NAME OF CLERK <i>None</i></p>	
<p>89. NAME OF CLERK <i>None</i></p>		<p>90. NAME OF CLERK <i>None</i></p>		<p>91. NAME OF CLERK <i>None</i></p>		<p>92. NAME OF CLERK <i>None</i></p>	
<p>93. NAME OF CLERK <i>None</i></p>		<p>94. NAME OF CLERK <i>None</i></p>		<p>95. NAME OF CLERK <i>None</i></p>		<p>96. NAME OF CLERK <i>None</i></p>	
<p>97. NAME OF CLERK <i>None</i></p>		<p>98. NAME OF CLERK <i>None</i></p>		<p>99. NAME OF CLERK <i>None</i></p>		<p>100. NAME OF CLERK <i>None</i></p>	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHINGORE 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11548

CERTIFICATE OF DEATH

11529

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park 18x-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Spring Valley Trailer Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donna Middle Lee Last MURPHY				4. DATE OF DEATH Month October Day 17 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-15-58	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 2 Days 2		IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Patrick Steven MURPHY				14. MOTHER'S MAIDEN NAME Nancy Lee BERNGEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline Membrane Disease 773.5 DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 33 hrs 33 hrs							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 16, 1959 , to October 17, 1958 , that I last saw the deceased alive on October 17, 1958 , and that death occurred at 8:32A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED J. C. PARKE, JR., LT, MC, USN Bethesda 14, Maryland ACTUAL SIGNATURE J. C. PARKE, JR. M.D. U. S. Naval Hospital, NNMC 10-17-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, WashDC				24a. REC'D BY REGISTRAR DATE OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2051161XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth Evelyn Neal</u>				4. DATE OF DEATH <u>10 - 9 - 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-07</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR: Months <u>10</u> Days <u>9</u> Hours <u>19</u> Min. <u>58</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John M. Studeman</u>				14. MOTHER'S MAIDEN NAME <u>Grace Browning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma, 170X</u> DUE TO <u>Pulmonary Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>(2) Metastatic Carcinoma</u> DUE TO <u>Primary Adeno-Carcinoma of left Breast</u> MODICASTINUM							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>6 mo.</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 16, 1954</u> to <u>Oct 9, 1958</u> that I last saw the deceased alive on <u>Oct 8, 1958</u> , and that death occurred at <u>4:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>7835 Eastern Ave Silver Spring Md</u> DATE SIGNED <u>Oct 9, 1958</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 10/11/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>SPRINGDALE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CLINTON, IOWA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11531

Reg. Dist. No.

11549

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus			c. LENGTH OF STAY IN 1b Damascus		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 26224 Town Spring Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ralph W. Middle Nealan Last			4. DATE OF DEATH Month Oct. Day 11 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1919	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME Charles R. Nealan			14. MOTHER'S MAIDEN NAME Martha E. Hester		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-14-7468		17. INFORMANT Mrs Dora E. Nealan, Damascus, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic hemorrhage 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shot gun wound in left chest DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted shot gun wound			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-11-58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Liberty Baptist	
22d. LOCATION (City, town, or county) Lisbon, Howard Co. Md.		22e. NAME OF CEMETERY OR CREMATORY Damascus, Md.		22f. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mylesworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery

Maryland

Montgomery

Dunsmuir

Dunsmuir

20234 Town Landing Road

20234 Town Landing Road

Philip A. Keenan

Oct. 11

White

Feb. 28, 1919

Carson

Constitution

Kentucky

USA

Charles E. Keenan

Charles E. Keenan

No.

17-1-268

17-1-268

17-1-268

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17-1-268

Frank J. Broderick

17-1-268

17-1-268

17-1-268

17-1-268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4)
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11532

11550

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>X</i> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William J. Nealon</i>		4. DATE OF DEATH <i>Oct 28 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/16/74</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Policeman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ireland</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael Nealon</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mullen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Dorothy E. Blankenship same as #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Bladder</i> <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Prostate</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Infermiertes of age</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>5 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1953</i> to <i>date</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Oct 20</i> , 19 <i>58</i> , and that death occurred at <i>10:45 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>G Roland Gable</i> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>G. ROLAND GABLE</i>		<i>900-17-SK. N.W. - D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>10/31/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 30 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1900

Register No.

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1855</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>Frederick, Md</i></p>		<p>6. OCCUPATION</p> <p><i>Farmer</i></p>	
<p>7. MARITAL STATUS</p> <p><i>Married</i></p>		<p>8. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>	
<p>9. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>10. TIME OF DEATH</p> <p><i>10:30 AM</i></p>	
<p>11. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>	
<p>13. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>14. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	

11551

11533

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Dist. of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 2900 Rittenhouse St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Raymond Neff				4. DATE OF DEATH Month Day Year October 24 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1898	
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Examiner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Joseph Neff				14. MOTHER'S MAIDEN NAME Amelia Page			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Son--William James Neff-----same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency 289.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Primary Amyloidosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year 18 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 20 , 19 57 to Oct 24 , 19 58 , that I last saw the deceased alive on Oct 24 , 19 58 , and that death occurred at 9:30 p. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Harell				ADDRESS (Street, city or town, state) DATE SIGNED 5516 Nebraska Ave 10/25/58			
PHYSICIAN'S NAME (Type) Robert B. Harell				Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.27.58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Inc. N.E.				24a. REC'D BY REGISTRAR DATE OCT 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

Page 100, 101

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35	
4. DATE OF DEATH 1918		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Typhoid fever	
7. PLACE OF BIRTH New York		8. OCCUPATION None		9. MARITAL STATUS Single	
10. DATE OF BIRTH 1883		11. PLACE OF DEATH Home		12. CAUSE OF DEATH Typhoid fever	
13. PLACE OF BIRTH New York		14. OCCUPATION None		15. MARITAL STATUS Single	
16. DATE OF BIRTH 1883		17. PLACE OF DEATH Home		18. CAUSE OF DEATH Typhoid fever	
19. PLACE OF BIRTH New York		20. OCCUPATION None		21. MARITAL STATUS Single	
22. DATE OF BIRTH 1883		23. PLACE OF DEATH Home		24. CAUSE OF DEATH Typhoid fever	
25. PLACE OF BIRTH New York		26. OCCUPATION None		27. MARITAL STATUS Single	
28. DATE OF BIRTH 1883		29. PLACE OF DEATH Home		30. CAUSE OF DEATH Typhoid fever	
31. PLACE OF BIRTH New York		32. OCCUPATION None		33. MARITAL STATUS Single	
34. DATE OF BIRTH 1883		35. PLACE OF DEATH Home		36. CAUSE OF DEATH Typhoid fever	
37. PLACE OF BIRTH New York		38. OCCUPATION None		39. MARITAL STATUS Single	
40. DATE OF BIRTH 1883		41. PLACE OF DEATH Home		42. CAUSE OF DEATH Typhoid fever	
43. PLACE OF BIRTH New York		44. OCCUPATION None		45. MARITAL STATUS Single	
46. DATE OF BIRTH 1883		47. PLACE OF DEATH Home		48. CAUSE OF DEATH Typhoid fever	
49. PLACE OF BIRTH New York		50. OCCUPATION None		51. MARITAL STATUS Single	
52. DATE OF BIRTH 1883		53. PLACE OF DEATH Home		54. CAUSE OF DEATH Typhoid fever	
55. PLACE OF BIRTH New York		56. OCCUPATION None		57. MARITAL STATUS Single	
58. DATE OF BIRTH 1883		59. PLACE OF DEATH Home		60. CAUSE OF DEATH Typhoid fever	
61. PLACE OF BIRTH New York		62. OCCUPATION None		63. MARITAL STATUS Single	
64. DATE OF BIRTH 1883		65. PLACE OF DEATH Home		66. CAUSE OF DEATH Typhoid fever	
67. PLACE OF BIRTH New York		68. OCCUPATION None		69. MARITAL STATUS Single	
70. DATE OF BIRTH 1883		71. PLACE OF DEATH Home		72. CAUSE OF DEATH Typhoid fever	
73. PLACE OF BIRTH New York		74. OCCUPATION None		75. MARITAL STATUS Single	
76. DATE OF BIRTH 1883		77. PLACE OF DEATH Home		78. CAUSE OF DEATH Typhoid fever	
79. PLACE OF BIRTH New York		80. OCCUPATION None		81. MARITAL STATUS Single	
82. DATE OF BIRTH 1883		83. PLACE OF DEATH Home		84. CAUSE OF DEATH Typhoid fever	
85. PLACE OF BIRTH New York		86. OCCUPATION None		87. MARITAL STATUS Single	
88. DATE OF BIRTH 1883		89. PLACE OF DEATH Home		90. CAUSE OF DEATH Typhoid fever	
91. PLACE OF BIRTH New York		92. OCCUPATION None		93. MARITAL STATUS Single	
94. DATE OF BIRTH 1883		95. PLACE OF DEATH Home		96. CAUSE OF DEATH Typhoid fever	
97. PLACE OF BIRTH New York		98. OCCUPATION None		99. MARITAL STATUS Single	
100. DATE OF BIRTH 1883		101. PLACE OF DEATH Home		102. CAUSE OF DEATH Typhoid fever	

11453

CERTIFICATE OF DEATH

11534

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp. 1</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churehton</u> <u>022-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Nicony</u> Middle <u>—</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-28-96</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Kovacs</u>				14. MOTHER'S MAIDEN NAME <u>Helen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Son + Hosp. Records</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pericardial effusion</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>inemia</u> DUE TO (c) <u>Circulatory Shock</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>14 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-12-58</u> , 19 <u>—</u> , to <u>10-27-58</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>10-27-58</u> , 19 <u>—</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard L. Clapp</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park, Md</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD L. CLAPP</u>				DATE SIGNED <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Oct 30-1958</u>		22b. DATE THEREOF <u>—</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence</u>		22d. LOCATION (City, town, or county) (State) <u>St. Lawrence Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kilbuck Vatter</u> ADDRESS <u>254 Carroll St</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	
DATE <u>30-58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WYOMING STATE DEPARTMENT OF HEALTH - TALLAHASSEE, FL

21553

14333

<p>1. NAME OF DECEASED [Blank]</p>		<p>2. SEX [Blank]</p>		<p>3. RACE [Blank]</p>	
<p>4. DATE OF BIRTH [Blank]</p>		<p>5. PLACE OF BIRTH [Blank]</p>		<p>6. PLACE OF DEATH [Blank]</p>	
<p>7. DATE OF DEATH [Blank]</p>		<p>8. TIME OF DEATH [Blank]</p>		<p>9. CAUSE OF DEATH [Blank]</p>	
<p>10. MEDICAL HISTORY [Blank]</p>		<p>11. OCCUPATION [Blank]</p>		<p>12. HABIT [Blank]</p>	
<p>13. SIGNATURE OF DECEASED [Blank]</p>		<p>14. SIGNATURE OF WITNESS [Blank]</p>		<p>15. SIGNATURE OF DECEASED [Blank]</p>	
<p>16. SIGNATURE OF DECEASED [Blank]</p>		<p>17. SIGNATURE OF DECEASED [Blank]</p>		<p>18. SIGNATURE OF DECEASED [Blank]</p>	
<p>19. SIGNATURE OF DECEASED [Blank]</p>		<p>20. SIGNATURE OF DECEASED [Blank]</p>		<p>21. SIGNATURE OF DECEASED [Blank]</p>	
<p>22. SIGNATURE OF DECEASED [Blank]</p>		<p>23. SIGNATURE OF DECEASED [Blank]</p>		<p>24. SIGNATURE OF DECEASED [Blank]</p>	
<p>25. SIGNATURE OF DECEASED [Blank]</p>		<p>26. SIGNATURE OF DECEASED [Blank]</p>		<p>27. SIGNATURE OF DECEASED [Blank]</p>	
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<p>61. SIGNATURE OF DECEASED [Blank]</p>		<p>62. SIGNATURE OF DECEASED [Blank]</p>		<p>63. SIGNATURE OF DECEASED [Blank]</p>	
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<p>79. SIGNATURE OF DECEASED [Blank]</p>		<p>80. SIGNATURE OF DECEASED [Blank]</p>		<p>81. SIGNATURE OF DECEASED [Blank]</p>	
<p>82. SIGNATURE OF DECEASED [Blank]</p>		<p>83. SIGNATURE OF DECEASED [Blank]</p>		<p>84. SIGNATURE OF DECEASED [Blank]</p>	
<p>85. SIGNATURE OF DECEASED [Blank]</p>		<p>86. SIGNATURE OF DECEASED [Blank]</p>		<p>87. SIGNATURE OF DECEASED [Blank]</p>	
<p>88. SIGNATURE OF DECEASED [Blank]</p>		<p>89. SIGNATURE OF DECEASED [Blank]</p>		<p>90. SIGNATURE OF DECEASED [Blank]</p>	
<p>91. SIGNATURE OF DECEASED [Blank]</p>		<p>92. SIGNATURE OF DECEASED [Blank]</p>		<p>93. SIGNATURE OF DECEASED [Blank]</p>	
<p>94. SIGNATURE OF DECEASED [Blank]</p>		<p>95. SIGNATURE OF DECEASED [Blank]</p>		<p>96. SIGNATURE OF DECEASED [Blank]</p>	
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<p>100. SIGNATURE OF DECEASED [Blank]</p>		<p>101. SIGNATURE OF DECEASED [Blank]</p>		<p>102. SIGNATURE OF DECEASED [Blank]</p>	

RECEIVED
TALLAHASSEE, FL
JAN 10 1964

FILED
TALLAHASSEE, FL
JAN 10 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11552

CERTIFICATE OF DEATH

11535

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4hr. 25min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 525 Knollwood Drive. Apt. #104			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last NOBLE				4. DATE OF DEATH Month October Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-58	
9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 25		IF UNDER 24 HRS. Hours 4 Min. 25			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joe Bailey NOBLE				14. MOTHER'S MAIDEN NAME Joan JACKSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Joe Bailey Noble, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Primary Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity (26 wk gestation) DUE TO (c) 5 hours				INTERVAL BETWEEN ONSET AND DEATH 5 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 29, 1958 , to October 30, 1958 , that I last saw the deceased alive on October 30, 1958 , and that death occurred at 2:25A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David Harris				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC			
DATE SIGNED 10-30-58							
PHYSICIAN'S NAME (Type) D. HARRIS, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-58		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cemetery		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR NOV 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hana							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051242XVO

RECEIVED STATE DEPARTMENT OF HEALTH—BIRMINGHAM

1. *Staphylococcus aureus* 2. *Staphylococcus epidermidis* 3. *Staphylococcus saprophyticus* 4. *Staphylococcus sciuri* 5. *Staphylococcus carnosus* 6. *Staphylococcus hyicus* 7. *Staphylococcus epidermidis* 8. *Staphylococcus aureus* 9. *Staphylococcus aureus* 10. *Staphylococcus aureus* 11. *Staphylococcus aureus* 12. *Staphylococcus aureus* 13. *Staphylococcus aureus* 14. *Staphylococcus aureus* 15. *Staphylococcus aureus* 16. *Staphylococcus aureus* 17. *Staphylococcus aureus* 18. *Staphylococcus aureus* 19. *Staphylococcus aureus* 20. *Staphylococcus aureus* 21. *Staphylococcus aureus* 22. *Staphylococcus aureus* 23. *Staphylococcus aureus* 24. *Staphylococcus aureus* 25. *Staphylococcus aureus* 26. *Staphylococcus aureus* 27. *Staphylococcus aureus* 28. *Staphylococcus aureus* 29. *Staphylococcus aureus* 30. *Staphylococcus aureus* 31. *Staphylococcus aureus* 32. *Staphylococcus aureus* 33. *Staphylococcus aureus* 34. *Staphylococcus aureus* 35. *Staphylococcus aureus* 36. *Staphylococcus aureus* 37. *Staphylococcus aureus* 38. *Staphylococcus aureus* 39. *Staphylococcus aureus* 40. *Staphylococcus aureus* 41. *Staphylococcus aureus* 42. *Staphylococcus aureus* 43. *Staphylococcus aureus* 44. *Staphylococcus aureus* 45. *Staphylococcus aureus* 46. *Staphylococcus aureus* 47. *Staphylococcus aureus* 48. *Staphylococcus aureus* 49. *Staphylococcus aureus* 50. *Staphylococcus aureus* 51. *Staphylococcus aureus* 52. *Staphylococcus aureus* 53. *Staphylococcus aureus* 54. *Staphylococcus aureus* 55. *Staphylococcus aureus* 56. *Staphylococcus aureus* 57. *Staphylococcus aureus* 58. *Staphylococcus aureus* 59. *Staphylococcus aureus* 60. *Staphylococcus aureus* 61. *Staphylococcus aureus* 62. *Staphylococcus aureus* 63. *Staphylococcus aureus* 64. *Staphylococcus aureus* 65. *Staphylococcus aureus* 66. *Staphylococcus aureus* 67. *Staphylococcus aureus* 68. *Staphylococcus aureus* 69. *Staphylococcus aureus* 70. *Staphylococcus aureus* 71. *Staphylococcus aureus* 72. *Staphylococcus aureus* 73. *Staphylococcus aureus* 74. *Staphylococcus aureus* 75. *Staphylococcus aureus* 76. *Staphylococcus aureus* 77. *Staphylococcus aureus* 78. *Staphylococcus aureus* 79. *Staphylococcus aureus* 80. *Staphylococcus aureus* 81. *Staphylococcus aureus* 82. *Staphylococcus aureus* 83. *Staphylococcus aureus* 84. *Staphylococcus aureus* 85. *Staphylococcus aureus* 86. *Staphylococcus aureus* 87. *Staphylococcus aureus* 88. *Staphylococcus aureus* 89. *Staphylococcus aureus* 90. *Staphylococcus aureus* 91. *Staphylococcus aureus* 92. *Staphylococcus aureus* 93. *Staphylococcus aureus* 94. *Staphylococcus aureus* 95. *Staphylococcus aureus* 96. *Staphylococcus aureus* 97. *Staphylococcus aureus* 98. *Staphylococcus aureus* 99. *Staphylococcus aureus* 100. *Staphylococcus aureus*

(2) $\frac{1}{2} \log 2$

1992

11553

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>1yr 5mos.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 x -3</u> d. STREET ADDRESS <u>211 11th St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Aloysius NOLAN</u>				4. DATE OF DEATH Month Day Year <u>October 26 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-5-83</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry A. NOLAN</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann RYAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>WWI</u>			
17. INFORMANT <u>(D) Mrs. Margaret A. Morris, 4711 Glen Oak Rd.</u>				Address <u>Landover Hills, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, generalized</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated bowel</u> DUE TO (c) <u>Adenocarcinoma, cecum, metastatic</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>36 hrs</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, NMMC</u>	
20f. (City or town) <u>Bethesda 14, Maryland</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>May 31</u> , 1957, to <u>October 26</u> , 1958, that I last saw the deceased alive on <u>October 26</u> , 1958, and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U. S. Naval Hospital, NMMC</u> <u>10-27-58</u>							
ACTUAL SIGNATURE <u>H. S. IRONS, LT MC, USN</u>				PHYSICIAN'S NAME (Type) <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hanlon Funeral Home, 3831 Ga. Ave., NW, Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11563

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

11563

<p>1. Name of deceased (Print name and surname) JAMES J. JONES</p>		<p>2. Sex Male</p>		<p>3. Age 35 years</p>	
<p>4. Date of death May 1, 1963</p>		<p>5. Time of death 10:30 A.M.</p>		<p>6. Place of death Home</p>	
<p>7. Usual residence 123 Main St., Boston, Mass.</p>		<p>8. Date of birth April 15, 1928</p>		<p>9. Place of birth New York, N.Y.</p>	
<p>10. Cause of death (List all causes, giving the immediate cause first) Myocardial infarction Atherosclerosis Hypertension</p>		<p>11. Date of death certificate May 1, 1963</p>		<p>12. Signature of physician J. A. Smith, M.D.</p>	
<p>13. Signature of registrar J. B. Jones</p>		<p>14. Date of registration May 1, 1963</p>		<p>15. Place of registration Boston, Mass.</p>	

11554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban. Hospital</u>		d. STREET ADDRESS <u>6505 - 14th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Burruss</u> (OVERSTREET) <u>Street</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Training Officer US Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Burruss</u>		14. MOTHER'S MAIDEN NAME <u>Un-Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-01-6805</u>	
17. INFORMANT <u>William B. Overstreet</u> Address <u>3302 94th St. Kensington, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Emphysema</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>10/2</u> 19 <u>55</u> to <u>10/25</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/24</u> 19 <u>58</u> , and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Frank Y. Jagger Jr.</u> M.D. <u>5707 Wisconsin Ave</u>		DATE SIGNED <u>10/25/58</u>	
PHYSICIAN'S NAME (Type) _____		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	
22b. DATE THEREOF <u>10.28.58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>	
22d. LOCATION (City, town, or county) <u>Washington D.C.</u> (State) _____		24a. REC'D BY REGISTRAR <u>OCT 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		24c. REGISTRAR'S SIGNATURE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10153 SUTHERLAND ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle FRANCES Last OWENS				4. DATE OF DEATH Month OCT. Day 5 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/93	
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
13. FATHER'S NAME DAVID C. ALLEN				14. MOTHER'S MAIDEN NAME ROSE ANNE CONNELLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Leroy S. Owens, 10153 Sutherland Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/8 , 19 58 , to 10/5 , 19 58 , that I last saw the deceased alive on 10/4 , 19 58 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dean H. Harding				DATE SIGNED 10/6/58			
PHYSICIAN'S NAME (Type) DEAN H. HARDING				ADDRESS (Street, city or town, state) 113 Carroll St NW Wash 12 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10/8/58		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.				24a. REC'D BY REGISTRAR DATE OCT 7 '58			
24b. REGISTRAR'S SIGNATURE Arthur L. Kline				24c. REGISTRAR'S SIGNATURE Arthur L. Kline			

FURNERAL DIRECTOR'S SIGNATURE

ADDRESS

SILVER SPRING, MD.

DATE

FURNERAL DIRECTOR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17555

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		MOTHER'S MARRIAGE DATE	
JANUARY 5, 1933		MEMPHIS, TENNESSEE		MAY 19, 1957	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION	
JAMES EARL RAY		JAMES EARL RAY		FARMER	
EDUCATION		RELIGION		MANNER OF DEATH	
HIGH SCHOOL		METHODIST		SUICIDE	
PREVIOUS ILLNESS		CAUSE OF DEATH		CERTIFICATE NO.	
NONE		SUICIDE BY FIRE		17555	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
JAMES EARL RAY		JAMES EARL RAY		APRIL 10, 1968	

FILED

11556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 62 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Birmingham c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 40X-3 d. STREET ADDRESS Route #3, Box 1060E e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clyde Taylor Palmer			4. DATE OF DEATH Month Day Year October 28, 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1901		9. AGE (In years last birthday) yrs. 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Alabama			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Walter Lee Palmer			14. MOTHER'S MAIDEN NAME Mertie Blaylock				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 117-01-4281		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombophlebitis left lower extremity with 463X DUE TO inceptant gangrene Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis, Rheumatoid Heart Disease					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from August 27, 1958 , to October 28, 1958 , that I last saw the deceased alive on October 28, 1958 , and that death occurred at 2:08 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnold N. Weinberg M.D.		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) ARNOLD N. WEINBERG, M.D.		DATE SIGNED 10/28/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 10/29/58		22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or county) (State) Birmingham, Alabama							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR OCT 30 '58			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11454

CERTIFICATE OF DEATH

Reg. Dist. No.

11541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Sakoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Grant Avenue</u>		d. STREET ADDRESS <u>1 124 Grant Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>B.</u> Last <u>PHELPS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Navy yard - (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>Nancy Phelps</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-28-7094</u>	
		17. INFORMANT Address <u>Mrs Artemesia M. Phelps, 124 Grant Ave T.P.Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>352X Congestive failure - Acute</u> DUE TO (b) <u>Paralysis - accidental</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>9/30</u> , 19 <u>58</u> , to <u>10-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>58</u> , and that death occurred at <u>2:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. SARAJO</u>		ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave.</u> DATE SIGNED <u>10-14-58</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAJO</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 17, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St Md LOC</u>		24. REC'D BY REGISTRAR DATE <u>OCT 16 1958</u>	25. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>

11455

Item 8 Film G235 10-22-58 et

CERTIFICATE OF DEATH

11542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>109 Croydon Ct. Apt. 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Henry</u> Last <u>Philson</u>				4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Anna Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Hypostatic Pneumonia</u> DUE TO (b) <u>Chronic Myocarditis and Decomp.</u> DUE TO (c) <u>Generalized atherosclerosis & coronary insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>18 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/5/58</u> , 19 <u>58</u> , to <u>10/16/58</u> , that I last saw the deceased alive on <u>10/16/58</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard T Morse</u> M.D.				ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u> DATE SIGNED <u>10/16/58</u>			
PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>				<u>Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Macomb Hill</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W F Huntman & Son</u> ADDRESS <u>5932 La Ave</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11557

CERTIFICATE OF DEATH

11543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2726 Hemlock Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Bertha (none) Pollack				4. DATE OF DEATH Month Day Year October 18, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1918	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Dumanis DUMANIS				14. MOTHER'S MAIDEN NAME Ida Bloomstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 009-01-9966		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Reticulum Cell Sarcoma DUE TO (c) 200.0							
INTERVAL BETWEEN ONSET AND DEATH 1 month 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Failure, 2° to 18(b)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1958 , to October 18, 1958 , that I last saw the deceased alive on October 18, 1958 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-18-58 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Nathan S. Taylor M.D.							
PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20-1958		22c. NAME OF CEMETERY OR CREMATORY Nat'l Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church Va	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash DC				ADDRESS Wash DC		24a. REC'D BY REGISTRAR DATE OCT 20 1958	
				24b. REGISTRAR'S SIGNATURE Arthur E. King			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1937

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES M. WATSON		Male		45		Jan 15, 1892		Boston, Mass.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR	
Clerk		Heart Disease		Home		10:30 PM		[Signature]	
11. NAME OF PHYSICIAN		12. NAME OF FUNERAL HOME		13. NAME OF BURIAL PLACE		14. NAME OF MINISTER		15. NAME OF WITNESSES	
Dr. J. H. Smith		J. H. Smith		St. Paul's Church		Rev. J. H. Smith		J. H. Smith, J. H. Smith	
16. NAME OF NEXT OF KIN		17. NAME OF SURVIVORS		18. NAME OF DECEASED'S MOTHER		19. NAME OF DECEASED'S FATHER		20. NAME OF DECEASED'S SISTER	
Mrs. J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
21. NAME OF DECEASED'S BROTHER		22. NAME OF DECEASED'S SISTER		23. NAME OF DECEASED'S MOTHER		24. NAME OF DECEASED'S FATHER		25. NAME OF DECEASED'S SISTER	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
26. NAME OF DECEASED'S BROTHER		27. NAME OF DECEASED'S SISTER		28. NAME OF DECEASED'S MOTHER		29. NAME OF DECEASED'S FATHER		30. NAME OF DECEASED'S SISTER	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11558

CERTIFICATE OF DEATH

11544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4608 High Street</u>				d. STREET ADDRESS <u>4608 High Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>F</u> Last <u>PYLES</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1882</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H Pyles</u>				14. MOTHER'S MAIDEN NAME <u>Mary Livina Paxton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-3053</u>		17. INFORMANT <u>Bertha F. Pyles-wife-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, severe</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary sclerosis, severe</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 year +</u> <u>5 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>79</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>1953</u> to <u>Oct 1</u> , 1958, that I last saw the deceased alive on <u>Sept 4</u> , 1958, and that death occurred at <u>345 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 D.C.</u> DATE SIGNED <u>10-1-58</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St. Wash 15 D.C.</u>					
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15 D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>

Coroner notified and case released.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11456

CERTIFICATE OF DEATH

Reg. Dist. No. 11545

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D. C. 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>739 Oglethorpe St. N.E.</u>			
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Racher</u> Middle _____ Last <u>Racher</u>				4. DATE OF DEATH <u>10-20-58</u> Month <u>10</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-10</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____		IF UNDER 24 HRS. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Car Mgr.</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Barney Racher</u>				14. MOTHER'S MAIDEN NAME <u>Clara Gates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army-W.W.II</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Hospital Records</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY SCLEROSIS</u> DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>October 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 20</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Boris Rabkin</u> M.D. <u>1019 University Boulevard S. Springfield, Ill.</u> PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____		
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Wansky & Sons - Wash DC</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11559

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>10600 Nash Place</u>			
3. NAME OF DECEASED (Type or print) <u>James Edgar Rawlings</u>				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 26 1891</u>	9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraphic work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A.T. & T.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Cornelius Rawlings</u>				14. MOTHER'S MAIDEN NAME <u>Alice Bouis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Wife <u>Dorothy M. Rawlings</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Hepatitis</u> DUE TO (c) <u>Carcinoma Ampulla of Vater</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>10 Day</u> <u>8 Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 3</u> , 19 <u>42</u> to <u>Oct 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4413 Bradley Lane</u> DATE SIGNED <u>Cherry Chase 15 Md</u>							
ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u> M.D.							
PHYSICIAN'S NAME (Type) <u>BRADLEY D. HODGKINS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphreys</u> ADDRESS <u>8434 La. Ave Silver Spring Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>10-15-1918</i>		5. PLACE OF DEATH <i>Home</i>	
6. OCCUPATION <i>Teacher</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MEDICAL HISTORY <i>None</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>		13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF WITNESS <i>John Doe</i>	
26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>	
36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>	
56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>	
66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF WITNESS <i>John Doe</i>	
86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>	
96. SIGNATURE OF WITNESS <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

1. I hereby certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of October, 1918.

2. I hereby certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of October, 1918.

3. I hereby certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of October, 1918.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11547

Item 18, & b, Film G-235 10/27/58.cac

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b X Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. And Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Susie Redmond		4. DATE OF DEATH Month Day Year Oct. 8, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/07
9. AGE (in years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Owens		14. MOTHER'S MAIDEN NAME ? Ownes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hosp. Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (a) CEREBRAL HEMORRHAGE, LEFT, MASSIVE, DUE TO (b) Cerebral vascular accident INTERVAL BETWEEN ONSET AND DEATH FEW DAYS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hematoma rt. parietal region			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported collapsed in garden at home	
20c. TIME OF INJURY Month Day Year xx 10/7/58 Hour p. m.	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Kensington Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 10/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/11/58	22c. NAME OF CEMETERY OR CREMATORY ANDREW CHAPEL CEMETERY	22d. LOCATION (City, town, or county) (State) ANDREW CHAPEL, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR OCT 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

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505/02

112

10557 10558

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4616 Rosedale Ave.		d. STREET ADDRESS 4616 Rosedale Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle S. Last REED		4. DATE OF DEATH Month Oct. Day 5, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1881
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months 3 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John J. Reed		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I		16. SOCIAL SECURITY NO. 578-0500310	
17. INFORMANT Daughter		Address Mrs. Betty Thompson Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary aocl. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 hr. unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1949 , 19 58 , to 5 Octob. 19 58 , that I last saw the deceased alive on 29 Sept. 19 58 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7659 Georgetown Rd. - Bethesda 14, Md. DATE SIGNED 6 Oct 58			
ACTUAL SIGNATURE John M. Wyman		M.D. Bethesda 14, Md.	
PHYSICIAN'S NAME (Type) John M. Wyman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-8-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DADCT 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11561

CERTIFICATE OF DEATH

11549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 96 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Jo Last Reed				4. DATE OF DEATH Month October Day 13 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1923	
9. AGE (In years last birthday) 35 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William E. O'Shields		14. MOTHER'S MAIDEN NAME Mattie L. Garrett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 422-22-8266 unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 173x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Choriocarcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1958 , to October 13, 1958 , that I last saw the deceased alive on October 13, 1958 , and that death occurred at 3:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald A. Kellogg M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/13/58					
PHYSICIAN'S NAME (Type) DONALD A. KELLOGG, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/14/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Collinsville Cemetery		22d. LOCATION (City, town, or county) (State) DeKalb County, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE OCT 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11562

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy REICHEL				4. DATE OF DEATH Month October Day 14 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-58	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Julius REICHEL				14. MOTHER'S MAIDEN NAME Doris Valerie SCHUCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Alfred J. Reichel, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4 days							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 10, 1958 , to October 14, 1958 , that I lost saw the deceased olive on October 14, 1958 , and that death occurred at 2:45A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 10-14-58 ACTUAL SIGNATURE Howard A. Pearson PHYSICIAN'S NAME (Type) H. A. PEARSON, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-16-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Demaine Memorial Chapel, 520 S. Wash. St.				24a. REC'D BY REGISTRAR OCT 15 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11563

CERTIFICATE OF DEATH

11551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>112723 Atherden Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Remines</u>		4. DATE OF DEATH Month Day Year <u>10 23 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 21 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Chas. Freed</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harold Remines</u> Address <u>Husband - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of larynx with</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>local & distal metastases</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>10-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-23-58</u> , 19 <u>58</u> , and that death occurred at <u>9:35p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris Remines</u>		DATE SIGNED <u>10-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Silver Spring Md.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, BURNING (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lee & Sons</u> ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11552

11458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSP.		d. STREET ADDRESS 5318 COLORADO AVE. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Last RITCHIE		4. DATE OF DEATH Month 10 / Day 9 Year 1958	
5. SEX fe	6. COLOR OR RACE wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/86
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Dept of Agriculture		10b. KIND OF BUSINESS OR INDUSTRY Pa.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John P. Ritchie		14. MOTHER'S MAIDEN NAME Annie Liller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Pt's Hesp. Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ATHEROSCLEROSIS DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 10 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 SEPT. 1958 to 9 OCT. 1958 that I last saw the deceased alive on 9 OCT. 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lee B. Snow		DATE SIGNED 10/9/58	
PHYSICIAN'S NAME (Type) Lee B. Snow		ADDRESS (Street, city or town, state) 9013 FLOWER AVE. SILVER SPRING, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 10/10/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11553

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11459

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8624 Flower Ave</u>		d. STREET ADDRESS <u>1 8624 Flower Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Violet Love Roberts</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-1905</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u>	
11. IF UNDER 24 HRS. Hours <u>2</u> Min.		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Traversa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-38-5663</u>	
17. INFORMANT <u>Richard Roberts</u>		Address <u>Steu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>fatal</u> <u>dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>10/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, INC.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 9 '58</u>	
ADDRESS <u>Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11551

HAWAIIAN STATE DEPARTMENT OF HEALTH - HONOLULU
MEDICAL EXAMINER'S CERTIFICATE OF DEATHNOT FOR
RECORD

11

1. NAME OF DECEASED <u>JOHN A. BROWN</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>	
4. OCCUPATION <u>SALES</u>		5. MARITAL STATUS <u>MARRIED</u>		6. PLACE OF BIRTH <u>MAINE</u>	
7. DATE OF DEATH <u>11-15-1918</u>		8. TIME OF DEATH <u>10:30 PM</u>		9. PLACE OF DEATH <u>HOME</u>	
10. CAUSE OF DEATH <u>HEART DISEASE</u>		11. MANNER OF DEATH <u>NATURAL</u>		12. SIGNATURE OF EXAMINER <u>[Signature]</u>	
13. SIGNATURE OF NEXT OF KIN <u>[Signature]</u>		14. SIGNATURE OF WITNESS <u>[Signature]</u>		15. SIGNATURE OF CLERK <u>[Signature]</u>	

11564

Items 8,9 Film G235 10-28-58 et

CERTIFICATE OF DEATH

11554

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4702 Rosedale Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Horatio Middle R Last Rogers				4. DATE OF DEATH Month October Day 24 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 12, 1900	
9. AGE (In years last birthday) 57 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Rhode Island	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur Rogers		14. MOTHER'S MAIDEN NAME Cornelia Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I & II		16. SOCIAL SECURITY NO. WW I & II		17. INFORMANT Helen P. Rogers-Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bronchogenic carcinoma DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hrs 20 mos.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1949 to October 24, 1958 , that I last saw the deceased alive on 23 Oct , 19 58 , and that death occurred at 4:19 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7659 Georgetown Rd., Bethesda, Md. DATE SIGNED 10/24/58 ACTUAL SIGNATURE John M. Wyman PHYSICIAN'S NAME (Type) John M. Wyman, M. D. 7659 Georgetown Rd., Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE OCT 27 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11565

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>mmty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elney</u>		c. LENGTH OF STAY IN 1b <u>50 A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yakethurst</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen. Hosp.</u>			d. STREET ADDRESS <u>R. 7 J. # 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elliss</u> Middle <u>Russell</u> Last <u>Jr.</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-58</u>		9. AGE (In years last birthday) yrs. <u>0</u> Months <u>29</u> Days <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elliss Russell</u>			14. MOTHER'S MAIDEN NAME <u>Ruby Frazer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hoyf. Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u> (c) <u>Upper Respiratory Infection</u> DUE TO <u>Upper Respiratory Infection</u> cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-18-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seals Farm Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Etchison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray G. Barber</u>			ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 24 '58</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11582
CERTIFICATE OF DEATH

11577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 wks</u> x <u>Manor Club</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookgrove Chronic Hosp</u>		d. STREET ADDRESS <u>4004 Beverly Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Anna B. Saltzman</u>		4. DATE OF DEATH <u>Oct 23 1958</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 9-1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Louis - Mo. - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank Reno</u>		14. MOTHER'S MAIDEN NAME <u>Mary Meek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. S. H. Burgess</u>		Address <u>4004 Beverly Rd Manor Club 11d Day</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334x</u> <u>Arasmia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Hypertrophic Left</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/29/58</u> to <u>10/23/58</u> that I last saw the deceased alive on <u>10/23/58</u> 12:15 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. B.</u> M.D. <u>Sandy</u>		ADDRESS (Street, city or town, state) <u>10/23/58</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>DR. T. W. BIRD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hinkle Co 2901-14th St N.W.</u>		24a. REC'D BY REGISTRAR <u>OCT 24 '58</u>	
ADDRESS <u>Washington D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11566

CERTIFICATE OF DEATH

11556

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 8 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8611 LYNNBROOK DR.				e. STREET ADDRESS 8611 LYNNBROOK DR			
3. NAME OF DECEASED (Type or print) First MARGARET Middle CRAWFORD Last SARGENT				4. DATE OF DEATH Month 10 Day 13 Year 1958			
5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JULY 13, 1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 3 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT EMPLOYEE, RETIRED				10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT EMPLOYEE, RETIRED		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME HARRY CARROLL SARGENT				14. MOTHER'S MAIDEN NAME MARGARET CRAWFORD BIDDLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT SEN, CRAWFORD C. SARGENT, Address 8611 LYNNBROOK DR BETHESDA, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Bronchial pneumonia DUE TO Senility and emaciation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO 5 years (c) 491X Degenerative arthritis, generalized						INTERVAL BETWEEN ONSET AND DEATH 72 hrs 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Degenerative arthritis, generalized						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 18 , 19 58 , to Oct 13 , 19 58 , that I lost sows the deceased olive on October 11 , 19 58 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert H. Goale				ADDRESS (Street, city or town, state) 4630 Montgomery Ave, Bethesda Md			
PHYSICIAN'S NAME (Type) ROBERT N. COALE MD				DATE SIGNED 10/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/58		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Philadelphia, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11466 CERTIFICATE OF DEATH

11557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5608 Randolph Road				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
f. STREET ADDRESS 4986 Battery Lane				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle A Last SAUTER				4. DATE OF DEATH Month Oct. Day 12 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1877	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 26		IF UNDER 24 HRS. Hours 26 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Bus College		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John S. Gilliss				14. MOTHER'S MAIDEN NAME Leanna Ricketts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 5608 Randolph Rd., Rockville, Md Miss Myrtle Gilliss -sister-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral-vascular disease (hemorrhage) DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 16 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1956 , to October 12, 1958 , that I last saw the deceased alive on October 11, 1958 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 8237 Georgia Ave. Silver Spring, Md.				DATE SIGNED Oct 12, 1958			
ACTUAL SIGNATURE Aaron H. Traum				M.D. 8237 Georgia Ave. Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Aaron H Traum				8237 Georgia Ave. Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/58		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 10/57

Item 18 Film 235 10-31-58 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11558

11567

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Alexandria		83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1710 Crestwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Donald Theodore SCHWOB				4. DATE OF DEATH Month Day Year October 8 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-08	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S.State Dept.		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver O. SCHWOB				14. MOTHER'S MAIDEN NAME Bertha P. SHEETS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 317-10-6047		17. INFORMANT Address Wife, Mrs. Ruth H. Schwob, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured esophageal varices 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Portal hypertension DUE TO Carcinoma of liver (c) Metastatic carcinoma of liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Metastatic carcinoma, lung, bilateral.						INTERVAL BETWEEN ONSET AND DEATH 5 min. 1 yr 18 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16 1958, to October 8 1958, that I last saw the deceased alive on October 8 1958, and that death occurred at 9:25P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Horgan M.D.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC 10-9-58 DATE SIGNED			
PHYSICIAN'S NAME (Type) J. T. HORGAN LT MC USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-58		22c. NAME OF CEMETERY OR CREMATORY Local Cemetery		22d. LOCATION (City, town, or county) (State) Moundville W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisconsin Ave., N.W.				24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

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1950

MASSACHUSETTS DEPARTMENT OF HEALTH - BACILLARIE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11569

CERTIFICATE OF DEATH

11560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill <i>16X-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home				d. STREET ADDRESS 5669--Bock Terrace			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SUSIE Middle ELLENA Last SCOTT				4. DATE OF DEATH Month Oct. Day 10 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29-1860		9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Novelty Shop		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Williams T. Simmons				14. MOTHER'S MAIDEN NAME Mary C. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Albert C. Scott 5669--Bock Terr. S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fracture left hip (Aug 21 1958)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 8 , 19 58 , to Oct 10 , 19 58 , that I last saw the deceased alive on Oct 9 , 19 58 , and that death occurred at 2:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnon H. Traim M.D.				ADDRESS (Street, city or town, state) 8237 Georgia Ave - Silver Spring Md 20910			
DATE SIGNED 10-10-58							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-58		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria Va	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bro.				ADDRESS 1661 - Good Hope Rd SE W 12 St. 20102		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11570

CERTIFICATE OF DEATH

Reg. Dist. No.

11561

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				d. STREET ADDRESS BLACKBURN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CALEB Middle ARTHUR Last SETZER				4. DATE OF DEATH Month OCT. Day 2 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/86	
9. AGE (In years lost birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Manufacturer				10b. KIND OF BUSINESS OR INDUSTRY Drexell Furniture Co.		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Matthew Coleman Setzer				14. MOTHER'S MAIDEN NAME Cynthia Elvira Moody			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 244-09-1552 A		17. INFORMANT Address Mrs. Myrtle L. Setzer, Blackburn Rd. Burtonsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. proplegia, thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X INTERVAL BETWEEN ONSET AND DEATH 3 days 1 Month							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 54 , to Oct , 19 58 , that I last saw the deceased alive on Oct 1 , 19 58 , and that death occurred at 2:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. Samuel Spry, M.D. 10/2/58 PHYSICIAN'S NAME (Type) A. D. BONIFANT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/5/58		22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Biska		23a. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE OCT 6 '58		24b. REGISTRAR'S SIGNATURE Anthony S. Kraw	

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

11571

CERTIFICATE OF DEATH

11562

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>3342 STUYVESANT PL. N.W.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSP.</u>				d. STREET ADDRESS <u>644</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD LAWRENCE SHANKLE</u>				4. DATE OF DEATH Month Day Year <u>OCT. 27 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 16, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOVT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUREAU OF ENGINEERING</u>		11. BIRTHPLACE (State or foreign country) <u>FREDRICK COUNTY MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN LUTHER SHANKLE</u>				14. MOTHER'S MAIDEN NAME <u>ANGLEBORER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DAUGHTER MRS GOTH RENARD - 3341 Stuyvesant</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROS</u> DUE TO (c) <u>HYPERTENSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 MO.</u> <u>YEARS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 4</u> , 19 <u>58</u> , to <u>Oct. 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 27</u> , 19 <u>58</u> , and that death occurred at <u>5:10</u> P. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Paul W. Taylor M.D.</u> M.D. <u>2150 PA. AVE. N.W. WASH. D.C.</u>							
PHYSICIAN'S NAME (Type) <u>PAUL N. TAYLOR M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/30/58</u>		<u>Cedar Hill Cem.</u>		<u>Brittland Rd Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>510 3 WIS. AVE</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Cherry Chase Funeral Home, Wash. D.C.</u>				DATE <u>OCT 30 '58</u>		<u>Arthur S. Kious</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11563

Reg. Dist. No.

11572

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairway Hills *Glen Echo</u>		c. LENGTH OF STAY IN 1b <u>x Fairway Hills -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6707 Barr Road</u>			d. STREET ADDRESS <u>6707 Barr Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>S.</u> Middle <u>SHELLY</u> Last			4. DATE OF DEATH Oct. 4, 1958 19		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1912</u>		9. AGE (in years last birthday) <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ex. Secy.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Veg. Owners Assn. Pennsylvania</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Robert L. Shelly</u>			14. MOTHER'S MAIDEN NAME <u>Hulda Siebert</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>187-07-294</u>		17. INFORMANT <u>Edith R. Shelly-Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/4/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>10/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>		22d. LOCATION (City, town, or county) <u>Huntingdon, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11503

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WEST VIRGINIA
STATE DEPARTMENT OF HEALTH

Jan 1910

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE		PLACE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11573

Reg. Dist. No. 215

11564

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 72 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1616 16th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy		First "A"		Middle SLACK		Lost	
4. DATE OF DEATH October 8 1958		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-89	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George SLACK		14. MOTHER'S MAIDEN NAME Josephine BLACK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Not known	
17. INFORMANT Son, Paul D. Slack, same as item #2 above		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4-6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Montgomery		(State) Maryland	
21. I certify that I attended the deceased from July 29, 1958, to October 8, 1958, that I last saw the deceased alive on October 7, 1958, and that death occurred at 3:30A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 10-8-58			
ACTUAL SIGNATURE E. J. Rupnik		M.D.		PHYSICIAN'S NAME (Type) E. J. RUPNIK LCDR MC USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St., NW, Washington, DC		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE C. S. Kraw	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11565

11574

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN lb <u>82 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>26</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>			d. STREET ADDRESS <u>Emory Lane</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Henry SMITH</u>			4. DATE OF DEATH Month Day Year <u>October 7 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-2-94</u>		9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Benjamin F. SMITH</u>			14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Betty LUCAS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWI		16. SOCIAL SECURITY NO. <u>Not known</u>	17. INFORMANT Address <u>Washington, D.C.</u> <u>(Sister) Mrs. Emma Tanner, 3101 Sherman Ave., NE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right pneumonectomy procedure</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7 1/2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma right lung</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-8-58</u>	
EXAMINER'S NAME (Type) <u>Frank J. BROSCART, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowden</u> ADDRESS <u>Robert Snowden, Rockville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11575

CERTIFICATE OF DEATH

11566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 420 Mansfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hazel K. Smith		4. DATE OF DEATH Month Oct. Day 16, Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1881
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary- Retired	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank C. Smith		14. MOTHER'S MAIDEN NAME Sarah Walbridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-22-2121	
17. INFORMANT Virginia Smith		Address 420 Mansfield Road Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 15 yrs. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 , 19____, to Oct. 16 , 19 58 , that I last saw the deceased alive on Oct. 10 , 19 58 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 13018 Georgia Ave. Silver Spring, Md. DATE SIGNED 10/16/58			
ACTUAL SIGNATURE A.W. Smith, M.D.		PHYSICIAN'S NAME (Type) A.W. Smith	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 10/18/58	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE OCT 17 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11576

CERTIFICATE OF DEATH

11567

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		d. STREET ADDRESS 3945 Conn. Ave. N. W.	
3. NAME OF DECEASED (Type or print) First Mamie Middle E. Last Smith		4. DATE OF DEATH Month Oct Day 9 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hesser		14. MOTHER'S MAIDEN NAME Clementi Sitcitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Edna Grammond-3024 Tilden St. N.W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 5-6 pm.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1942 to Oct 9, 1958 , that I last saw the deceased alive on Oct 9, 1958 , and that death occurred at 10:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Wardrop M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St. DATE SIGNED 10/9/58	
PHYSICIAN'S NAME (Type) W. B. WARDROP, M.D.		837 Bonifant St. Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/13/58	22c. NAME OF CEMETERY OR CREMATORY Lakeview cemetery	22d. LOCATION (City, town, or county) (State) Hamilton, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR Oct 14 58 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11568

11577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 17 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4822 Morgan Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
3. NAME OF DECEASED (Type or print) Martha Jane Smith		4. DATE OF DEATH Month 10 Day 10 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1983
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sion David Williams		14. MOTHER'S MAIDEN NAME Elizabeth Georgiana Atkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 242-16-2140B	
17. INFORMANT Margaret S Williams (Daughter)		Address 4822 Morgan Dr Chevy Chase, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration atelectasis & pneumonia DUE TO 191.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emaciation DUE TO Squamous cell carcinoma, primary site, unknown (c) 1-2 years		INTERVAL BETWEEN ONSET AND DEATH 36 hrs 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to October 10, 1958 , that I last saw the deceased alive on Oct. 9, 1958 , and that death occurred at 11:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4630 Montgomery Ave., Bethesda, Md DATE SIGNED 10/10/58 ACTUAL SIGNATURE Robert H Coale M.D. ROBERT N. COALE M.D. 4630 MONTGOMERY AVE. BETHESDA MD PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/13/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Oakwood		22d. LOCATION (City, town, or county) (State) Raleigh, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11578

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 35 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY 85x-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morgantown d. STREET ADDRESS 117 Arch Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Margaret Smith			4. DATE OF DEATH Month Day Year October 16 1958				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH October 5, 1956		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Peru			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Freeman P. Smith				
14. MOTHER'S MAIDEN NAME Rose Pilegge			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				
16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Suppurative Meningitis (pneumococcal) 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute Lymphocytic Leukemia DUE TO (c) 5 min INTERVAL BETWEEN ONSET AND DEATH 5 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from September 11 1958 , to October 16, 1958 , that I last saw the deceased alive on October 16, 1958 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/16/58 ACTUAL SIGNATURE Leonard Garren M.D. PHYSICIAN'S NAME (Type) Leonard Garren, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
Burial		Oct. 19, 1958		Morgantown, W. Va.			
22d. LOCATION (City, town, or county)		(State)					
Morgantown, W. Va.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Md.			24a. REC'D BY REGISTRAR DATE OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
11538
CERTIFICATE OF DEATH

11538
BOND

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of burial		19. Signature of burial		20. Signature of burial	
21. Signature of burial		22. Signature of burial		23. Signature of burial		24. Signature of burial	
25. Signature of burial		26. Signature of burial		27. Signature of burial		28. Signature of burial	
29. Signature of burial		30. Signature of burial		31. Signature of burial		32. Signature of burial	
33. Signature of burial		34. Signature of burial		35. Signature of burial		36. Signature of burial	
37. Signature of burial		38. Signature of burial		39. Signature of burial		40. Signature of burial	
41. Signature of burial		42. Signature of burial		43. Signature of burial		44. Signature of burial	
45. Signature of burial		46. Signature of burial		47. Signature of burial		48. Signature of burial	
49. Signature of burial		50. Signature of burial		51. Signature of burial		52. Signature of burial	
53. Signature of burial		54. Signature of burial		55. Signature of burial		56. Signature of burial	
57. Signature of burial		58. Signature of burial		59. Signature of burial		60. Signature of burial	
61. Signature of burial		62. Signature of burial		63. Signature of burial		64. Signature of burial	
65. Signature of burial		66. Signature of burial		67. Signature of burial		68. Signature of burial	
69. Signature of burial		70. Signature of burial		71. Signature of burial		72. Signature of burial	
73. Signature of burial		74. Signature of burial		75. Signature of burial		76. Signature of burial	
77. Signature of burial		78. Signature of burial		79. Signature of burial		80. Signature of burial	
81. Signature of burial		82. Signature of burial		83. Signature of burial		84. Signature of burial	
85. Signature of burial		86. Signature of burial		87. Signature of burial		88. Signature of burial	
89. Signature of burial		90. Signature of burial		91. Signature of burial		92. Signature of burial	
93. Signature of burial		94. Signature of burial		95. Signature of burial		96. Signature of burial	
97. Signature of burial		98. Signature of burial		99. Signature of burial		100. Signature of burial	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11579

CERTIFICATE OF DEATH

Reg. Dist. No.

11570

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 1405 Somerset Place, N.W.			
3. NAME OF DECEASED (Type or print) First Myrtle Middle Jane Last Smith				4. DATE OF DEATH Month October Day 7 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/86	9. AGE (In years lost birthday) yrs. 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME FRANKLIN SUDDATH				14. MOTHER'S MAIDEN NAME ANNA HOBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louis F. Napoli	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - arrhythmia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.H.F. DUE TO (c) A-S. H. Disease				INTERVAL BETWEEN ONSET AND DEATH 1 hr. 12 min @ 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8/31, 1957 to 10/7, 1958 , that I last saw the deceased alive on 10/7, 1958 , and that death occurred at 10:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones				ADDRESS (Street, city or town, state) Rockville Md. DATE SIGNED 10/7/58			
PHYSICIAN'S NAME (Type) Stephen N. Jones				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cen. Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. 2901 14th St., N.W.				24a. REC'D BY REGISTRAR DATE OCT 10 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11571

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11467			
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN lb <u>3 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5930 Le May Rd</u>		d. STREET ADDRESS <u>15930 Le May Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ralph Carter Spaulding</u>		4. DATE OF DEATH <u>Oct 23 1958</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt U.S.N.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Carter Spaulding</u>		14. MOTHER'S MAIDEN NAME <u>Louise Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Barbara Spaulding</u>		Address <u>Stue 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-23-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 27 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11460

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		d. STREET ADDRESS 5603 Georgia Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martin Middle Sproger Last		4. DATE OF DEATH Month October Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Indrikis Sproger		14. MOTHER'S MAIDEN NAME Ilze -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 060-10-9348	
17. INFORMANT Mrs. Laura Sproger		Address Wash. D.C. 5603 Georgia Ave., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISSECTING AORTIC ANEURYSM (c) HYPERTENSIVE AND ARTERIOSCLEROTIC VASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 18 HOURS 8 YEARS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JULY 1955 , to OCT 24 1958 , that I last saw the deceased alive on OCT 23, 1958 , and that death occurred at 1:35 PM, 10/24/58 , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert L. Krichmar M.D.		ADDRESS (Street, city or town, state) 7733 ARASKA AVENUE WASH DC DATE SIGNED OCT 24 1958	
PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR		WASH DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/27/58	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901		ADDRESS Wash. D.C. 14th St., N.W.	24a. REC'D BY REGISTRAR DATE OCT 27 1958
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17460

11975

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>		<p>3. RACE White</p>		<p>4. DATE OF BIRTH May 19, 1928</p>		<p>5. PLACE OF BIRTH Jackson, Tennessee</p>	
<p>6. DATE OF DEATH April 4, 1968</p>		<p>7. PLACE OF DEATH Memphis, Tennessee</p>		<p>8. CAUSE OF DEATH FIRE</p>		<p>9. MANNER OF DEATH Suicide</p>		<p>10. SIGNATURE OF DECEASED (None)</p>	
<p>11. SIGNATURE OF NEXT OF KIN (None)</p>		<p>12. SIGNATURE OF PHYSICIAN (None)</p>		<p>13. SIGNATURE OF CORONER (None)</p>		<p>14. SIGNATURE OF DEATH REGISTRAR (None)</p>		<p>15. SIGNATURE OF COUNTY CLERK (None)</p>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11573

Reg. Dist. No.

11580

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 2712 Wisconsin Ave.	
3. NAME OF DECEASED (Type or print) Ruby B. Sprouse		4. DATE OF DEATH October 26 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2 1902 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY City Government	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samford N Butler		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 249-32-3150	
17. INFORMANT William B. Sprouse, 3527-B. BATHING Ave Norfolk VA		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Cerebral Hemorrhage, Right 442X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschant		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschant		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-27-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-58	
22c. NAME OF CEMETERY OR CREMATORY LongCove Cem		22d. LOCATION (City, town, or county) (State) Abbeville So Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		24a. REC'D BY REGISTRAR NOV 3 '58	
ADDRESS 4812 E. Ave N. Deal		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

FOR STATE
HEALTH DEPT.

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNABY 20
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11550

15573

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Place of Death		Cause of Death		Manner of Death	
Occupation		Education		Religion		Marital Status	
Social History		Medical History		Family History		Previous Illnesses	
Physical Examination		Mental Examination		Autopsy		Disposition of Body	
Signature of Examiner		Signature of Coroner		Signature of Medical Officer		Signature of Registrar	
Date of Examination		Date of Coroner's Report		Date of Medical Officer's Report		Date of Registrar's Report	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11468

CERTIFICATE OF DEATH

11574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 19 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15,015 Rosecroft Road		d. STREET ADDRESS 15,015 Rosecroft Road	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle THOMAS Last STEWART		4. DATE OF DEATH Month OCTOBER Day 27 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sup't. of Pullman Company		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM STEEN STEWART		14. MOTHER'S MAIDEN NAME ANN ZIPPORAH WARREN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO XXXX		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mrs. Agnes H. Stewart, 15,015 Rosecroft Rd. Rockville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Drasmania Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Chronic Nephritis DUE TO Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days years years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 58 , to 10/28 , 19 58 , that I last saw the deceased alive on 10-28 , 19 58 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE J. W. BIRD		M.D. Sonny S. S. M.	
PHYSICIAN'S NAME (Type) J. W. BIRD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/30/58	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Blaska		24. REC'D BY REGISTRAR OCT 29 58	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11581

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion R. Strickling</u>				4. DATE OF DEATH Month Day Year <u>Oct. 20 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-13-1865</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Scranton Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>David Richards</u>				14. MOTHER'S MAIDEN NAME <u>Mary Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records & Son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsisemia</u> 538X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sedative Angina</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 19, 1958</u> to <u>Oct. 20, 1958</u> , that I last saw the deceased alive on <u>Oct. 19, 1958</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.W. Bird</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Springs, Maryland 10/20/58</u>			
PHYSICIAN'S NAME (Type) <u>J.W. Bird, M.D.</u>				ADDRESS <u>Sandy Springs, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>DATE OCT 22 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>N.Y.</i> b. COUNTY <i>Westchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b <i>6 hours</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Yonkers</i> <i>69X-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		d. STREET ADDRESS <i>112 Ramsey Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Thornton Anthony Sullivan</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 29, 1892</i>
9. AGE (In years last birthday) <i>65 yrs.</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Commander U.S. Coast Guard (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brooklyn, N.Y.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cornelius A. Sullivan</i>		14. MOTHER'S MAIDEN NAME <i>Laura Frances Chadwick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes WW 1 & 2</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Lillian Sullivan (wife)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>10-20-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Trans. & Burial</i>	22b. DATE THEREOF <i>Oct. 21, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>KENSICO CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>VALHALLA NEW YORK</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>		24a. REC'D BY REGISTRAR <i>Arthur L. Hunt</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>OCT 22 1958</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11583 CERTIFICATE OF DEATH

11578

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1yr 2mos.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2310 Connecticut Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Anna Huber SYPHER			4. DATE OF DEATH Month Day Year October 9 1958		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-5-73		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY - - -		13. BIRTHPLACE (State or foreign country) Rhode Island	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME Bartlett J. CROMWELL		16. MOTHER'S MAIDEN NAME Lizzie Stiles HUBER	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		18. SOCIAL SECURITY NO. None		19. INFORMANT (D) Miss Elizabeth C. Sypher	
20. ADDRESS Chasleton Hotel		21. CITY Washington, D. C.		22. STATE D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis, chronic INTERVAL BETWEEN ONSET AND DEATH 1 year					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington		20g. (County) District of Columbia		20h. (State) D. C.	
21. I certify that I attended the deceased from July 21 , 1958 , to October 9 , 1958 , that I last saw the deceased alive on October 9 , 1958 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 10-10-58					
ACTUAL SIGNATURE W. J. Jacoby, Jr.		M.D. W. J. Jacoby, Jr.			
PHYSICIAN'S NAME (Type) W. J. JACOBY, JR., LCDR MC USN		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington		22e. (State) Virginia		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons		ADDRESS 1756 Penna Ave, NW, Wash, DC		24a. REC'D BY REGISTRAR OCT 14 '58	
24b. REGISTRAR'S SIGNATURE James D. Hume		24c. DATE OCT 14 '58			

11584

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. STREET ADDRESS <u>11928 Bluhill Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Thomas</u> Middle <u>Dwdney</u> Last <u>Thayer</u>		4. DATE OF DEATH		Month <u>October</u> Day <u>6</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 4, 1911</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ice Cream Business</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fred Thayer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hernlon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-05-2253</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA RIGHT AND LEFT</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic Cirrhosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 2, 1958</u> , to <u>October 6, 1958</u> , that I last saw the deceased alive on <u>October 6, 1958</u> , and that death occurred at <u>1:15 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>10/7/58</u> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <u>John Oates</u>		M.D. <u>John Oates, M.D.</u>		PHYSICIAN'S NAME (Type) <u>John Oates, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pharmaceutical Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pharmaceutical Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chuan Fung</u>				ADDRESS <u>5103 Wisconsin Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fung</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11. JOURNAL OF HEALTH AND HUMAN SERVICES ADMINISTRATION

11585

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONT</u> Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>14</u> hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> Suburban Hospital				d. STREET ADDRESS <u>5504 Lincoln Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>LeRoy</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 5, 1897</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Policeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Rockville, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u> (An orphan)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wife</u>		Address <u>Mrs. Beatrice H. Thompson</u> <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, Acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7:00</u> <u>7</u> , 19 <u>53</u> , to <u>Oct 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 21</u> , 19 <u>58</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>DeWitt E. DeLauter</u>				ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD</u>		DATE SIGNED <u>10/22/58</u>	
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLauter</u>				<u>Bethesda 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11333

Date of Death 1918		Place of Death Boston	
Name of Deceased John J. ...		Sex Male	
Age 35		Race Irish	
Usual Residence 1234 Main Street, Boston		Cause of Death Inflammation of the lungs	
Date of Birth 1883		Place of Birth Ireland	
Name of Physician Dr. J. H. ...		Name of Undertaker J. J. ...	
Name of Informant J. J. ...		Name of Registrar J. J. ...	
Signature of Informant J. J. ...		Signature of Registrar J. J. ...	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11581

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3905- Sand Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Neellie May Tipton</u>		4. DATE OF DEATH <u>Oct 18 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-04</u>
9. AGE (In years last birthday) <u>53 yrs.</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Elem. School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. Bea</u>		14. MOTHER'S MAIDEN NAME <u>James Stone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harold Tipton</u>	
17. INFORMANT <u>Name & Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous attacks</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) <u>Prince George Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 20 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Trans</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11587 CERTIFICATE OF DEATH

11582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57, 10210 Colesville Rd.—Silver Spring		f. STREET ADDRESS 10210-Colesville Rd.	
3. NAME OF DECEASED (Type or print) First ALICE Middle Marie Last TRAVISS				4. DATE OF DEATH Month October Day 12 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1914	
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME H. William Mc Guire				14. MOTHER'S MAIDEN NAME Hannah Sheehan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 207-01-2150		17. INFORMANT Address Mr. Harvey E. Traviss, 10210 Colesville Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Carcinoma Breast DUE TO (c) 4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 20, 1958 to Oct 11, 1958 , that I last saw the deceased alive on Oct 11, 1958 , and that death occurred at 1158A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave. Kensington, Md. DATE SIGNED 10-12-58							
ACTUAL SIGNATURE George Sharpe M.D.							
PHYSICIAN'S NAME (Type) George Sharpe MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/15/58		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11588

CERTIFICATE OF DEATH

11583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthursburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthursburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>md R-124</u>		d. STREET ADDRESS <u>1 md R-124</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Randolph</u> Last <u>Vollmer</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-69</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mrs. Melborne F. Watson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pyrawk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eliz. Mainhart</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>286.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>malnutrition</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>58</u> , to <u>11-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-20</u> , 19 <u>58</u> , and that death occurred at <u>9: A M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. J. Broschart</u> M.D.		DATE SIGNED <u>8 Russell Ave</u>	
PHYSICIAN'S NAME (Type) <u>FRANK J. Broschart</u>		<u>Garthursburg md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>30th + R St. Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett B. Gattner</u>		ADDRESS <u>Garthursburg Md</u>	
24a. REC'D BY REGISTRAR <u>OCT 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hana</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. COLOR</p>		<p>9. RELIGION</p>		<p>10. EDUCATION</p>		<p>11. SOCIAL CLASS</p>		<p>12. PLACE OF DEATH</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. CAUSE OF DEATH</p>		<p>16. MANNER OF DEATH</p>		<p>17. PLACE OF INTERMENT</p>		<p>18. NAME OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF CORONER</p>		<p>21. SIGNATURE OF REGISTRAR</p>		<p>22. SIGNATURE OF WITNESSES</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF NEXT OF KIN</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

11589 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown-Rural-Box 199				c. LENGTH OF STAY IN 1b Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) Near Germantown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown-Rural-Box 199			
d. NAME OF HOSPITAL (If not in hospital, give street address) Near Germantown				d. STREET ADDRESS 1 Near Germantown			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Annie Luray Wachter				4. DATE OF DEATH Month Day Year October 11 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 15, 1892	
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thadeus Filby				14. MOTHER'S MAIDEN NAME Horzeanie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mr. Bruce E. Wachter-Same as item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 443X DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Chronic Myocarditis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19 Oct 11 , 19 58 , that I last saw the deceased alive on Oct 5 , 19 58 , and that death occurred at 11:45 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 N. Frederick Ave. DATE SIGNED ACTUAL SIGNATURE Luciano I. Leal M.D. 108 N. Frederick Ave. PHYSICIAN'S NAME (Type) Luciano I. Leal Gaithersburg Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE OCT 16 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11590

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 50 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Falls Church 83x-3	
d. STREET ADDRESS 6004 Arlington Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Rodney WALLACE, Jr.		4. DATE OF DEATH Month Day Year October 6 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-82
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rodney WALLACE		14. MOTHER'S MAIDEN NAME Frances LITTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Wife, Mrs. Nellie V. Wallace, same as #2	
17. INFORMANT Wife, Mrs. Nellie V. Wallace, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, acute 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leakage at anastomosis site DUE TO Post-operative bowel resection for adenocarcinoma of transverse colon (c) of transverse colon		INTERVAL BETWEEN ONSET AND DEATH 24 hours Unknown 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 18, 1958 , to October 6, 1958 , that I last saw the deceased alive on October 6, 1958 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Troy		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 10-6-58	
PHYSICIAN'S NAME (Type) J. W. TROY CDR MC USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington		24a. REC'D BY REGISTRAR DATE OCT 8 '58	
24b. REGISTRAR'S SIGNATURE C. L. K. K.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11591

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 2½ Months.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9301 Weaver Street			
d. STREET ADDRESS 9301 Weaver St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWIN First H. Middle WALKER Last				4. DATE OF DEATH Month Oct. Day 9, Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1873	9. AGE (In years birthday) yrs. 84	IF UNDER 1 YEAR Months 10 Days 15	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Printers Supply Co. - Pres.			10b. KIND OF BUSINESS OR INDUSTRY Supply Co. - Pres.		11. BIRTHPLACE (State or foreign country) Kentucky		
12. CITIZEN OF WHAT COUNTRY? U. S.			13. FATHER'S NAME William Calvin Walker				
14. MOTHER'S MAIDEN NAME Selby Harvey			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 578-38-8874			17. INFORMANT Son				
18. ADDRESS 4504 Wetherill Rd. Westmoreland Hills, Md.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 , to Oct 9, 1958 , that I last saw the deceased alive on Oct 7, 1958 , and that death occurred at 5:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 Kennedy St NW Wash. DC DATE SIGNED Oct 10, 1958							
ACTUAL SIGNATURE M.F. OTTMAN M.D. M.F. OTTMAN							
PHYSICIAN'S NAME (Type) M.F. OTTMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Preston Edward Walter</u>				4. DATE OF DEATH <u>October 2 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-44</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred D. Walter</u>				14. MOTHER'S MAIDEN NAME <u>Margueriet Cooley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u> <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 26</u> , 1958, to <u>Oct. 2</u> , 1958, that I last saw the deceased alive on <u>Oct. 2</u> , 1958, and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. F. Thibadeau</u>				ADDRESS (Street, city or town, state) <u>10111 Colasville Rd. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>10/2/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (Give town, or county) (State) <u>Prince George's Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>12 D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

11-1-55

Case No. 11-1-55

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1-1-11		Baltimore, Md.		Baltimore, Md.		Heart Disease		1-1-55		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Manner of Death		Certified by		Date		Signature		Signature		Signature	
Teacher		Married		High School		Catholic		White		White		Natural		J. Doe, M.D.		1-1-55		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness	
1-1-55		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Cause of Death		Manner of Death		Certified by		Date		Signature		Signature		Signature		Signature		Signature		Signature		Signature		Signature	
Heart Disease		Natural		J. Doe, M.D.		1-1-55		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness	
1-1-55		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

RECEIVED
BALTIMORE, MD
JAN 1 1955

CERTIFICATE OF DEATH

State of Maryland

County of Prince George's

City of Washington

Age

Sex

Color

Marital Status

Occupation

U.S.A.

Residence

Place of Birth

Date of Birth

Place of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Witness

Witness

Witness

Witness

Witness

Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11589
Items 11 & 12, File 6234, 10/10/58 for
11593
STATE OF MARYLAND—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Acres	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Care Home 7927 Wis. Ave.		d. STREET ADDRESS 4922 Greenway Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HATTIE Middle I Last WEISEL		4. DATE OF DEATH Month Oct Day 4 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 84? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Census	
11. BIRTHPLACE (State or foreign country) Unknown Wyoming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL WEISEL		14. MOTHER'S MAIDEN NAME Isabel Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Robt L. Waters 4922 Greenway Drive, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage Gastro-Intestinal Massive 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombo-Phlebitis Left Leg Ascending DUE TO (c) Arteriosclerosis-Severe-Generalized.		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 24 hr. 20 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Oct. , 19 58 , to 4 Oct , 19 58 , that I last saw the deceased alive on 4 Oct , 19 58 , and that death occurred at 3:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Georgetown Road, Bethesda 14, Md. DATE SIGNED 10/4/58			
ACTUAL SIGNATURE John G. Ball		M.D. John G. Ball	
PHYSICIAN'S NAME (Type) John G. Ball			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/5/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOSEPH F. BIRCH KSONS 3034 M ST NW		ADDRESS 3034 M ST NW	
24a. REC'D BY REGISTRAR OCT 6 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

Thomson's Atomic Model

11590

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		16 15.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMCM				d. STREET ADDRESS 4503 Emerson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Talmage WHITESELL				4. DATE OF DEATH Month Day Year October 18 1958					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-4-90			
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor				10b. KIND OF BUSINESS OR INDUSTRY D.C. Transit		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME David WHITESELL				14. MOTHER'S MAIDEN NAME Alice HALL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 12/1918-9/1919				16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT (D) Mrs. Edith M. Meals, same as #2 above				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction 024X DUE TO Cachexia, marked, due to mental deterioration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilis, tertiary, tabes dorsalis DUE TO (c) Syphilis, tertiary, tabes dorsalis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Vascular Disease, benign								INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos. 15 1/2 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 15 1958 to October 18 1958 , that I last saw the deceased alive on October 17 1958 , and that death occurred at 4:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMCM DATE SIGNED 10-18-58 ACTUAL SIGNATURE F. S. Caldwell M.D. F. S. CALDWELL, LT, MC, USN Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons Funeral Home, Hyattsville,				ADDRESS Md.		24a. REC'D BY REGISTRAR DATE OCT 21 1958			
24b. REGISTRAR'S SIGNATURE Arthur S. Frazer									

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

CERTIFICATE OF DEATH

THE DAY OF THE YEAR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11595 CERTIFICATE OF DEATH

11591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 3821 Kanawha St. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gertrude West Williamson First Middle Last				4. DATE OF DEATH October 30, 1958 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Thomas West				14. MOTHER'S MAIDEN NAME Gertrude Phelps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John F. Splain-same as 2-d Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis 4VRS				INTERVAL BETWEEN ONSET AND DEATH 20 min 5 VRS 10 VRS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1945 to Oct 30, 1958 , that I last saw the deceased alive on Oct 29, 1958 , and that death occurred at 2:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1030 P DATE SIGNED ACTUAL SIGNATURE Horace H. Custis M.D. HORACE H. CUSTIS, JR., M.D. PHYSICIAN'S NAME (Type) 1852 Columbia Road, Washington, 9, D. C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/58		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Huns ADDRESS Washington 9, D.C.				24a. REC'D BY REGISTRAR NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

11463

CERTIFICATE OF DEATH

11592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> <i>Wash. D.C.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Wash. D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 47x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Nash. Santi Hospital</i>		d. STREET ADDRESS <i>Sheraton Park Hotel</i>	
3. NAME OF DECEASED (Type or print) First <i>Ida</i> Middle <i>Frances</i> Last <i>Wilmoth</i>		4. DATE OF DEATH Month <i>10</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/7/3</i>
9. AGE (In years last birthday) <i>70+</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>New York</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Abrams Shotwell</i>	
14. MOTHER'S MAIDEN NAME <i>Elmira Clark</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, myocardial hypertrophy</i> DUE TO <i>Coronary atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Paul Maffray</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sell stroms Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>23 mos</i> <i>3 wks</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>refused</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1940</i> , 19____, to <i>10/19/58</i> , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas H Wolohin</i>		DATE SIGNED <i>10/19/58</i>	
PHYSICIAN'S NAME (Type) <i>Chas H. Wolohin</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll St Takoma Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-22-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home + Mary Ann Mc</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 22 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11 1963

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JANUARY 5, 1933		MOBILE, ALABAMA		UNITED STATES	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		ATTORNEY	
NAME OF SPOUSE		NAME OF FATHER		NAME OF MOTHER	
JANET A. RAY		JAMES EARL RAY, JR.		LUCILLE RAY	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		MEMPHIS, TENNESSEE	
DETAILS OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS	
DECEASED WAS FOUND BY		PHYSICIAN'S SIGNATURE		WITNESS SIGNATURE	
FAMILY MEMBER		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JANUARY 5, 1933		MOBILE, ALABAMA		UNITED STATES	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		ATTORNEY	
NAME OF SPOUSE		NAME OF FATHER		NAME OF MOTHER	
JANET A. RAY		JAMES EARL RAY, JR.		LUCILLE RAY	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		MEMPHIS, TENNESSEE	
DETAILS OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS	
DECEASED WAS FOUND BY		PHYSICIAN'S SIGNATURE		WITNESS SIGNATURE	
FAMILY MEMBER		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	

11 1963

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 10, SECTION 10-101, OF THE MARYLAND CODE, TITLE 10, SUBTITLE 1, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 10, SECTION 10-102, OF THE MARYLAND CODE, TITLE 10, SUBTITLE 1.

11596 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1915 PLYERS MILL ROAD				e. STREET ADDRESS 1915 PLYERS MILL ROAD			
d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MELVIN Middle P. Last WOLF				4. DATE OF DEATH Month OCTOBER Day 25 Year 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/04		9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUYER, Hechinger Co.		10b. KIND OF BUSINESS OR INDUSTRY Building Supplies		11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OTTO WOLF				14. MOTHER'S MAIDEN NAME SARAH PACH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 578-05-9264		17. INFORMANT Mrs. Pearl M. Wolf, 1915 Plyers Mill Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA WITH METASTASES DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 1 YEAR							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. , 1957, to OCT. 25 , 1958, that I last saw the deceased alive on OCT. 25 , 1958, and that death occurred at 8 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Robert L. Krichmar M.D.				7723 ALASKA AVE NW WASH DC			
PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR M.D.				WASH DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		10/28/58		GLENWOOD CEMETERY		WAVERLY, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Bicks				24a. REC'D BY REGISTRAR DATE OCT 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S NAME (Type) WARNER E. PUMPHREY, INC.				23. ADDRESS SILVER SPRING, MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED STEPHEN J. BROWN</p>		<p>2. SEX MALE</p>	
<p>3. AGE 45</p>		<p>4. DATE OF DEATH 1945</p>	
<p>5. PLACE OF DEATH HOME</p>		<p>6. CAUSE OF DEATH HEART DISEASE</p>	
<p>7. PLACE OF BIRTH BALTIMORE, MARYLAND</p>		<p>8. OCCUPATION LABORER</p>	
<p>9. MARITAL STATUS MARRIED</p>		<p>10. DATE OF MARRIAGE 1935</p>	
<p>11. NAME OF SPOUSE MARY J. BROWN</p>		<p>12. NAME OF FATHER JOHN B. BROWN</p>	
<p>13. NAME OF MOTHER SARAH J. BROWN</p>		<p>14. NAME OF PHYSICIAN DR. J. H. SMITH</p>	
<p>15. NAME OF BURIAL PLACE GREENWOOD CEMETERY</p>		<p>16. NAME OF MINISTER REV. J. H. SMITH</p>	
<p>17. NAME OF FUNERAL HOME GREENWOOD FUNERAL HOME</p>		<p>18. NAME OF CARRIER GREENWOOD CARRIER</p>	
<p>19. NAME OF UNDERTAKER GREENWOOD UNDERTAKER</p>		<p>20. NAME OF COFFIN GREENWOOD COFFIN</p>	
<p>21. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>22. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>23. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>24. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>25. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>26. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>27. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>28. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>29. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>30. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>31. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>32. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>33. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>34. NAME OF CASKIN GREENWOOD CASKIN</p>	
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<p>59. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>60. NAME OF CASKIN GREENWOOD CASKIN</p>	
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<p>65. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>66. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>67. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>68. NAME OF CASKIN GREENWOOD CASKIN</p>	
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<p>71. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>72. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>73. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>74. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>75. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>76. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>77. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>78. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>79. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>80. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>81. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>82. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>83. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>84. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>85. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>86. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>87. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>88. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>89. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>90. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>91. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>92. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>93. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>94. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>95. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>96. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>97. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>98. NAME OF CASKIN GREENWOOD CASKIN</p>	
<p>99. NAME OF CASKIN GREENWOOD CASKIN</p>		<p>100. NAME OF CASKIN GREENWOOD CASKIN</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11597 CERTIFICATE OF DEATH

Reg. Dist. No.

11594

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 1/2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ledeau Gardens Nursing Home		d. STREET ADDRESS Washington, D.C. 47X-3	
3. NAME OF DECEASED (Type or print) William T Wolgrey, Sr.		4. DATE OF DEATH Month October Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1865
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 93 Days 93 Hours 93 Min. 93	IF UNDER 24 HRS. Months 93 Days 93 Hours 93 Min. 93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William T Wolfrey		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Beazley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Nursing Home Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO Arteriosclerosis, Mod Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Thrombosis, right leg DUE TO Old chronic coronary artery disease (c) Old chronic coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 56 , to Oct 27 19 58 , that I last saw the deceased alive on Oct 25 19 58 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		ADDRESS (Street, city or town, state) 10609 Concord St.	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/29/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE OCT 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11598

CERTIFICATE OF DEATH

Reg. Dist. No.

11595

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 77 days			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Pontiac c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 59X-3 d. STREET ADDRESS 375 East Sheffield Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Betty Maxine Woods			4. DATE OF DEATH Month Day Year October 24, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1927		9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Monroe Millstead			14. MOTHER'S MAIDEN NAME Elsie Bennard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unascertainable	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA 173X DUE TO METASTATIC CHORIOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 173X DUE TO 173X (c) 173X					INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 5 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from August 8, 1958 , to October 24, 1958 , that I last saw the deceased alive on October 24, 1958 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. 4:45 ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
ACTUAL SIGNATURE Theodore L. Goodfriend, MD		DATE SIGNED 10/24/58			
PHYSICIAN'S NAME (Type) THEODORE L. GOODFRIEND, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit	22b. DATE THEREOF 10/24/58	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Pontiac, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 27 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10/57

11599 CERTIFICATE OF DEATH

11596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl (Newborn)</u> Middle <u>Yates</u> Last <u>Yates</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/58</u>	9. AGE (In years lost birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>42</u>	IF UNDER 24 HRS. Min. <u>42</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Douglas B. Yates</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Murphy</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Douglas B. Yates</u>		Address <u>4918 Auburn Ave. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>20 Oct</u> , 19 <u>58</u> , to <u>20 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Oct</u> , 19 <u>58</u> , and that death occurred at <u>12:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>R. H. Mitchell</u>			M.D. <u>8215 Wisconsin Ave</u>				
PHYSICIAN'S NAME (Type) <u>R. H. Mitchell</u>			<u>Bethesda Md</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1899 CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18

1899

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	